

105

HEALTH CARE REFORM (Part 11)

Y 4. EN 2/3: 103-120

Health Care Reform (Part 11), Serial... **RINGS**

BEFORE THE
SUBCOMMITTEE ON
COMMERCE, CONSUMER PROTECTION, AND
COMPETITIVENESS
OF THE

COMMITTEE ON
ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

ON

H.R. 3800

A BILL TO ENSURE INDIVIDUAL AND FAMILY SECURITY THROUGH
HEALTH CARE COVERAGE FOR ALL AMERICANS IN A MANNER THAT
CONTAINS THE RATE OF GROWTH IN HEALTH CARE COSTS AND PRO-
MOTES RESPONSIBLE HEALTH INSURANCE PRACTICES, TO PROMOTE
CHOICE IN HEALTH CARE, AND TO ENSURE AND PROTECT THE
HEALTH CARE OF ALL AMERICANS

FEBRUARY 1 and 14, 1994

Serial No. 103-120

Printed for the use of the Committee on Energy and Commerce



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HEALTH CARE REFORM

TUESDAY, FEBRUARY 1, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON COMMERCE, CONSUMER PROTECTION,
AND COMPETITIVENESS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2218, Rayburn House Office Building, Hon. Cardiss Collins (chairwoman) presiding.

Mrs. COLLINS. Good morning. This is the first hearing of the Energy and Commerce Subcommittee on Commerce, Consumer Protection and Competitiveness for the second session of the 103d Congress and you are all welcome.

Today's hearing of the subcommittee will focus on two titles of H.R. 3600, the Health Security Act. Title X addresses the handling of health benefits paid for by workers' compensation insurance and automobile insurance. Title XI outlines the rules proposed to regulate the sale and servicing of health insurance policies during the transition period.

Subtitles A, B and C of title X are directed toward coordinating and, eventually, merging portions of workers' compensation insurance and automobile insurance into the new health care system. Normally, when an individual becomes ill, he or she goes to the doctor, receives treatment, and arranges payment for the bill. If he or she has health insurance coverage, that person can file a claim for reimbursement or make other arrangements for the health insurer to pay the health care provider.

The questions of fault, cause and liability do not arise. In contrast, if an individual is injured in the workplace, develops a work-related illness, or is injured in an automobile accident, the question of who is to blame for the injury or illness, what caused the injury or illness, and who is liable for payment for treatment become important issues.

In addition, for both workers' compensation and automobile insurance, total claim costs to the insurer may be affected by treatment decisions made by the health care practitioner.

Now, the Health Security Act would change the relationships between the employer, the insurer, the health care provider, and the injured or ill person. In so doing, it affects the operations of workers' compensation and auto insurance markets and the handling of injuries and illness.

Today's hearings will explore some of those changes and discuss the tradeoffs between, on one hand, consolidating the delivery and

financing of health care, and, on the other hand, maintaining separate systems which focus on rehabilitation for work-related injuries and illnesses and automobile accidents.

The other topic for examination at today's hearing is title XI of H.R. 3600, which establishes the rules health insurers, HMO's, and other health benefit providers are to follow during the interim between the enactment of the bill and the implementation of the alliance-based system of providing health care.

The provisions of title XI establish guaranteed coverage, limitations on policy cancellation, and caps on premium increases. These are worthy goals and I applaud the Clinton Task Force for hastening their adoption.

However, we have a potential for creating problems with pricing and solvency in the health insurance industry. As we consider the bill's proposals, it will be important for us to examine them in the context of solvency concerns so as not to create severe financial problems for otherwise competent and efficient providers.

Title XI also establishes a national health insurance risk pool. This provision will assure that any individual wishing to purchase health insurance will be able to do so, even if the underwriting standards of the private health insurance industry have judged this person to be uninsurable.

This is a major step forward in increasing access to health insurance for all Americans. According to witnesses we heard at an earlier hearing on health care reform, a large portion of the uninsured are willing to purchase insurance but cannot find an insurer willing to sell them coverage. The creation of a health insurance risk pool should end that particular problem.

Nonetheless, the experience of some States in establishing risk pools for other types of insurance suggests that a poorly conceived or poorly designed risk pool can undermine competition in the marketplace, facilitate redlining by private insurers, and increase the cost of providing insurance to all policyholders. Thus, it is critical that we carefully examine the plan creating such a pool to assure its success as an interim measure in increasing access to health care for all Americans.

I thank our witnesses for agreeing to appear before the subcommittee and look forward to hearing their testimony.

Mr. Stearns.

Mr. STEARNS. Thank you, Madam Chairwoman, and best wishes for our committee in the new year and delighted to be here. I am sorry to the folks in the audience that we don't have a bigger room. I guess we didn't know we were going to have so many wonderful people.

Since this subcommittee, Madam Chairwoman, has last met, we have all had an opportunity to return to our districts, talk to our constituents, have town meetings about the issues that concern them. I think we all realize that health care is an issue that is on everybody's mind. And my constituents have not hesitated to let me know how they feel on health care, too.

They are concerned about what we are doing here in Washington. They realize that our health care system has some serious problems that need to be addressed, but they are afraid that if we adopt the Clinton plan as currently written we will make a trip to

the doctor more frustrating than perhaps a trip even to the Motor Vehicles. And they don't want that and neither do I.

Those concerns seem particularly relevant when you look at the rules proposed by the Clinton administration or bringing the existing insurance market into line with their vision of the future. For instance, the Clinton plan takes two lines of insurance that are currently effective for the insured and stable for insurance companies, automobile medical and workman's compensation, and radically alters the market in which they operate. Today's workers' compensation insurance system often places injured employees under medical care, especially tailored to workplace injuries.

The Clinton plan would dismantle this system and replace it with one that values cost savings over getting the employee back to work through effective treatment. The problems presented by automobile medical coverage are also troubling. Furthermore, the transition section of the bill sets up a myriad of dysfunctional relationships in the insurance market.

Title XI creates a real impediment to the natural flow of business in the insurance industry. Traditionally insurance companies, like most other companies, kinds of companies, could enter new lines of business when they believed they would be profitable and exit them when they felt they were no longer getting a return on their investment. Unfortunately, the Clinton plan requires an insurance company to continue to provide health insurance from the date of enactment, regardless of profitability.

My constituents are just starting to get their lives back together again after Hurricane Andrew. After the next natural disaster, how do I explain to them that the company providing their homeowners' insurance could not pay its claims because the Federal Government had forced the company to continue pumping money into an unprofitable line of health insurance?

In addition, I am concerned about possible threats to workplace safety presented by a merger of the current workman's compensation system into the Clinton health care scheme. Workers' compensation premiums have always been closely tied to the employer's safety history. Employers have had an incentive to keep their workplace safe because the safer their workplace, the lower their premiums. Unless workers' compensation insurers and employers are able to closely manage the care of injured workers, the potential exists for premiums to skyrocket, without any hearings on the relative safety of the workplace.

The Clinton health reform plan is the ultimate square peg trying to fit into a round hole. We need to remember that you can't hammer that peg too hard without breaking the whole system. Thank you, Madam Chairwoman.

Madam Chairwoman, I would also like to make part of the record the Ranking Member on Energy and Commerce's opening comment, Carlos Moorhead, if I might.

Mrs. COLLINS. Without objection.

Mr. STEARNS. Thank you.

Mrs. COLLINS. Mr. Lehman, who is a member of our subcommittee, is ill today and will not be able to make his statement, and it is going to be included in the record, as all opening statements are going to be a part of the record today.

[Testimony resumes on p. 65.]

[The opening statements of Mr. Moorhead and Mr. Lehman, and the text of titles X and XI of H.R. 3600 follow:]

STATEMENT OF HON. CARLOS MOORHEAD

Thank you, Madam Chairwoman. I would like to thank you for holding today's hearing on the issues involved in a transition from our current system of health insurance to the system envisioned under H.R. 3600, the Clinton health plan. These are very important issues, and the distinguished chairwoman has been a leader in making sure that these topics are addressed.

In today's system of health insurance, Americans receive the highest quality of care anywhere. Polls consistently show that among people who have health insurance, they are satisfied with the kind of care they receive. Therefore, we should be very cautious when we try to "reform" our current health care system.

For instance, title 10 of the Clinton health plan deals with the medical components of workers compensation insurance and automobile insurance. These are both important coverages which provide meaningful benefits to consumers. Both provide coverage from the first dollar, so that consumers covered by these policies pay *nothing* when injured in the workplace or in an automobile accident. Further, the kind of care that injured workers receive is different from the kind of care provided by traditional health care providers—it is more specialized and is designed to get the employee back to work as quickly as possible. It's a system that works well and I have great reservations about changing it just so it fits into the Clinton's vision of the future of health care.

The transition rules covered by title 11 also cause me great concern. They appear to have been written with little concern for the financial health of insurance companies and could pose threats to insurer solvency far beyond the health care market.

This subcommittee has always prided itself on understanding the complex issues associated with the business of insurance. I hope that in our rush to "fix" the health care system, we do not end up breaking the rest of the insurance industry.

Thank you, Madam Chairwoman.

STATEMENT OF HON. RICHARD LEHMAN

Thank you, Madam Chairwoman. As we examine the issues involved with title X and title XI of the President's Health Security Act, we must consider them from all possible perspectives. I have not yet taken a position on any of the proposed health care bills, because I believe it is important to keep an open mind during the hearing process. Today's discussion raises several important issues which we can examine from a number of angles.

Of particular interest to me is the issue of workers compensation. President Clinton's Health Security Act is the only major health care proposal which addresses the inclusion of the medical components of property/casualty coverage, including workers compensation. We must consider the ramifications of separating the medical part of workers compensation from the disability part.

Proponents of the Clinton plan contend that the integration of workers compensation medical benefits into a new health care delivery system would result in increased cost savings. At the same time, providers of workers compensation insurance maintain that the coordination of workers comp and health insurance could, in fact, be much more costly than the current system. They argue that the Clinton plan would drive up indemnity costs by taking the ability to manage medical care away from those who have the financial incentive to provide aggressive treatment (employers and/or comp providers).

As you remember, California's workers compensation system has been plagued with a history of fraud. We must work to prevent such abuse, and find the most effective means of combating the skyrocketing costs of today's system. I look forward to today's testimony, which will explore the various approaches to workers compensation and other related issues.

103D CONGRESS
1ST SESSION

H. R. 3600

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 20, 1993

Mr. GEPHARDT (for himself, Mr. BONIOR, Mr. HOYER, Mr. FAZIO, Mrs. KENNELLY, Mr. LEWIS of Georgia, Mr. RICHARDSON, Mr. DINGELL, Mr. ROSTENKOWSKI, Mr. FORD of Michigan, Mr. WAXMAN, Mrs. COLLINS of Illinois, Mr. STARK, Mr. WILLIAMS, Mr. CLAY, Mr. BROOKS, Mr. MOAKLEY, Mr. ABERCROMBIE, Mr. ACKERMAN, Mr. ANDREWS of Maine, Mr. BARRETT of Wisconsin, Mr. BERMAN, Mr. BILBRAY, Mr. BLACKWELL, Mr. BORSKI, Mr. BROWN of California, Ms. BROWN of Florida, Mr. CARDIN, Mr. CLYBURN, Mr. COYNE, Mr. DE LUGO, Ms. DELAURO, Mr. DEUTSCH, Mr. DICKS, Mr. DIXON, Mr. DURBIN, Mr. EDWARDS of California, Mr. ENGEL, Ms. ENGLISH of Arizona, Ms. ESHOO, Mr. FALCONE, Mr. FILNER, Mr. FLAKE, Mr. FOGLIETTA, Mr. FRANK of Massachusetts, Mr. GEJDENSON, Mr. GIBBONS, Mr. HASTINGS, Mr. HILLARD, Mr. HINCHEY, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. JOHNSTON of Florida, Mr. KANJORSKI, Mr. KREIDLER, Mr. LaFALCE, Mr. LANTOS, Mr. LEVIN, Ms. LONG, Mr. MARTINEZ, Mr. MATSUI, Ms. MCKINNEY, Mrs. MEEK, Mr. MINGE, Mrs. MINK, Mr. MURPHY, Mr. MURTHA, Ms. NORTON, Mr. OBERSTAR, Mr. OBEY, Mr. OWENS, Mr. PASTOR, Mr. PAYNE of New Jersey, Mr. RAHALL, Mr. RANGEL, Mr. REYNOLDS, Mr. ROMERO-BARCELÓ, Mr. RUSH, Mr. SABO, Mr. SAWYER, Mr. SCOTT, Mr. SERRANO, Ms. SHEPHERD, Mr. SKAGGS, Ms. SLAUGHTER, Mr. SMITH of Iowa, Mr. STOKES, Mr. STRICKLAND, Mr. STUDDS, Mr. SWIFT, Mr. SYNAR, Mr. THORNTON, Mrs. THURMAN, Mr. TRAFICANT, Mr. UNDERWOOD, Mrs. UNSOELD, Mr. VENTO, Mr. WATT, Mr. WHEAT, Mr. WISE, and Mr. YATES) introduced the following bill; which was referred jointly to the Committee on Energy and Commerce, to the Committee on Ways and Means, and to the Committee on Education and Labor for consideration of such provisions in titles I, III, VI, VIII, X, and XI as fall within its jurisdiction pursuant to clause 1(g) of rule X; and concurrently, for a period ending not later than two weeks after all three committees of joint referral report to the House (or a later time

if the Speaker so designates), to the Committee on Armed Services for consideration of subtitle A of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(e) of rule X, to the Committee on Veterans' Affairs for consideration of subtitle B of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(u) of rule X, to the Committee on Post Office and Civil Service for consideration of subtitle C of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(o) of rule X, to the Committee on Natural Resources for consideration of subtitle D of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(n) of rule X, to the Committee on the Judiciary for consideration of subtitles C through F of title V and such other provisions as fall within its jurisdiction pursuant to clause 1(l) of rule X, to the Committee on Rules for consideration of sections 1432(d), 6006(f), and 9102(e)(5), and to the Committee on Government Operations for consideration of subtitle B of title V and section 5401

A BILL

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

1 *Be it enacted by the Senate and House of Representa-*
 2 *tives of the United States of America in Congress assembled,*

3

1 SECTION 1. SHORT TITLE; TABLE OF TITLES AND SUB-
2 TITLES.

3 (a) SHORT TITLE.—This Act may be cited as the
4 “Health Security Act”.

5 (b) TABLE OF TITLES AND SUBTITLES IN ACT.—The
6 following are the titles and subtitles contained in this Act:

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TITLE XI—TRANSITIONAL INSURANCE REFORM

1 **SEC. 2. FINDINGS.**

2 The Congress finds as follows:

3 (1) Under the current health care system in the
4 United States—

5 (A) individuals risk losing their health care
6 coverage when they move, when they lose or
7 change jobs, when they become seriously ill, or
8 when the coverage becomes unaffordable;

9 (B) continued escalation of health care
10 costs threatens the economy of the United
11 States, undermines the international competi-
12 tiveness of the Nation, and strains Federal,
13 State, and local budgets;

14 (C) an excessive burden of forms, paper-
15 work, and bureaucratic procedures confuses
16 consumers and overwhelms health care provid-
17 ers;

18 (D) fraud and abuse sap the strength of
19 the health care system; and

20 (E) health care is a critical part of the
21 economy of the United States and interstate
22 commerce, consumes a significant percentage of
23 public and private spending, and affects all in-
24 dustries and individuals in the United States.

25 (2) Under any reform of the health care
26 system—

6

1 (A) health insurance and high quality
2 health care should be secure, uninterrupted,
3 and affordable for all individuals in the United
4 States;

5 (B) comprehensive health care benefits
6 that meet the full range of health needs, includ-
7 ing primary, preventive, and specialized care,
8 should be available to all individuals in the
9 United States;

10 (C) the current high quality of health care
11 in the United States should be maintained;

12 (D) individuals in the United States should
13 be afforded a meaningful opportunity to choose
14 among a range of health plans, health care pro-
15 viders, and treatments;

16 (E) regulatory and administrative burdens
17 should be reduced;

18 (F) the rapidly escalating costs of health
19 care should be contained without sacrificing
20 high quality or impeding technological improve-
21 ments;

22 (G) competition in the health care industry
23 should ensure that health plans and health care
24 providers are efficient and charge reasonable
25 prices;

7

1 (H) a partnership between the Federal
2 Government and each State should allow the
3 State and its local communities to design an ef-
4 fective, high-quality system of care that serves
5 the residents of the State;

6 (I) all individuals should have a respon-
7 sibility to pay their fair share of the costs of
8 health care coverage;

9 (J) a health care system should build on
10 the strength of the employment-based coverage
11 arrangements that now exist in the United
12 States;

13 (K) the penalties for fraud and abuse
14 should be swift and severe; and

15 (L) an individual's medical information
16 should remain confidential and should be pro-
17 tected from unauthorized disclosure and use.

18 **SEC. 3. PURPOSES.**

19 The purposes of this Act are as follows:

20 (1) To guarantee comprehensive and secure
21 health care coverage.

22 (2) To simplify the health care system for con-
23 sumers and health care professionals.

1 (3) To control the cost of health care for em-
 2 ployers, employees, and others who pay for health
 3 care coverage.

4 (4) To promote individual choice among health
 5 plans and health care providers.

6 (5) To ensure high quality health care.

7 (6) To encourage all individuals to take respon-
 8 sibility for their health care coverage.

20 **TITLE X—COORDINATION OF**
 21 **MEDICAL PORTION OF WORK-**
 22 **ERS COMPENSATION AND**
 23 **AUTOMOBILE INSURANCE**

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1 **Subtitle A—Workers Compensation**

2 **Insurance**

3 **SEC. 10000. DEFINITIONS.**

4 In this subtitle:

5 (1) **INJURED WORKER.**—The term “injured
6 worker” means, with respect to a health plan, an in-
7 dividual enrolled under the plan who has a work-re-
8 lated injury or illness for which workers compensa-
9 tion medical benefits are available under State law.

10 (2) **SPECIALIZED WORKERS COMPENSATION**
11 **PROVIDER.**—The term “specialized workers com-
12 pensation provider” means a health care provider
13 that specializes in the provision of treatment relating
14 to work-related injuries or illness, and includes spe-
15 cialists in industrial medicine, specialists in occupa-
16 tional therapy, and centers of excellence in industrial
17 medicine and occupational therapy.

18 (3) **WORKERS COMPENSATION MEDICAL BENE-**
19 **FITS.**—The term “workers compensation medical
20 benefits” means, with respect to an enrollee who is
21 an employee subject to the workers compensation

22

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1 laws of a State, the comprehensive medical benefits
2 for work-related injuries and illnesses provided for
3 under such laws with respect to such an employee.

4 (4) WORKERS COMPENSATION CARRIER.—The
5 term “workers compensation carrier” means an in-
6 surance company that underwrites workers com-
7 pensation medical benefits with respect to one or
8 more employers and includes an employer or fund
9 that is financially at risk for the provision of work-
10 ers compensation medical benefits.

11 (5) WORKERS COMPENSATION SERVICES.—The
12 term “workers compensation services” means items
13 and services included in workers compensation medi-
14 cal benefits and includes items and services (includ-
15 ing rehabilitation services and long-term care serv-
16 ices) commonly used for treatment of work-related
17 injuries and illnesses.

18 **PART 1—HEALTH PLAN REQUIREMENTS**

19 **RELATING TO WORKERS COMPENSATION**

20 **SEC. 10001. PROVISION OF WORKERS COMPENSATION**
21 **SERVICES.**

22 (a) PROVISION OF BENEFITS.—Subject to subsection

23 (b)—

24 (1) REQUIREMENT FOR CERTAIN HEALTH
25 PLANS.—

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1 (A) IN GENERAL.—Each health plan that
2 provides services to enrollees through partici-
3 pating providers shall enter into such contracts
4 and arrangements as are necessary (in accord-
5 ance with subparagraph (B)) to provide or ar-
6 range for the provision of workers compensation
7 services to such enrollees, in return for payment
8 from the workers compensation carrier under
9 section 10002.

10 (B) PROVISION OF SERVICES.—For pur-
11 poses of this paragraph, a health plan provides
12 (or arranges for the provision of) workers com-
13 pensation services with respect to an enrollee if
14 the services are provided by—

15 (i) a participating provider in the
16 plan,

17 (ii) any other provider with whom the
18 plan has entered into an agreement for the
19 provision of such services, or

20 (iii) a specialized workers compensa-
21 tion provider (designated by the State
22 under 10011(b)), whether or not the pro-
23 vider is a provider described in clause (i)
24 or (ii).

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1 (2) INDIVIDUAL REQUIREMENT.—An individual
2 entitled to workers compensation medical benefits
3 and enrolled in a health plan (whether or not the
4 plan is described in paragraph (1)(A)) shall receive
5 workers compensation services through the provision
6 (or arrangement for the provision) of such services
7 by the health plan.

8 (3) EXCEPTIONS.—

9 (A) EMERGENCY SERVICES.—Paragraphs
10 (1) and (2) shall not apply in the case of emer-
11 gency services.

12 (B) ELECTING VETERANS, MILITARY PER-
13 SONNEL AND INDIANS.—Paragraphs (1) and
14 (2) shall not apply in the case of an individual
15 described in section 1004(b) and making an
16 election described in such section.

17 (4) USE OF SPECIALIZED WORKERS COMPENSA-
18 TION PROVIDERS.—If a participating State has des-
19 ignated under section 10011(b) specialized workers
20 compensation providers with respect to one or more
21 types of injuries or illnesses for a geographic area,
22 either a health plan or an injured worker who has
23 an injury or illness of such type may elect to provide
24 or receive the benefits under this subsection through
25 such a provider.

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1 (b) ALTERNATIVE PERMITTED.—Subsection (a) shall
2 not be construed as preventing an injured worker and a
3 workers compensation carrier from agreeing that workers
4 compensation services shall be provided other than by or
5 through the health plan in which the worker is enrolled.

6 (c) COORDINATION.—

7 (1) DESIGNATION OF CASE MANAGER.—Each
8 health plan shall employ or contract with one or
9 more individuals, such as occupational nurses, with
10 experience in the treatment of occupational illness
11 and injury to provide case management services with
12 respect to workers compensation services provided
13 through the plan under this section.

14 (2) FUNCTIONS OF CASE MANAGER.—The
15 health plan (through the case manager described in
16 paragraph (1)) is responsible for ensuring that—

17 (A) there is plan of treatment (when ap-
18 propriate) for each enrollee who is an injured
19 worker designed to assure appropriate treat-
20 ment and facilitate return to work;

21 (B) the plan of treatment is coordinated
22 with the workers compensation carrier, the em-
23 ployer, or both;

1319

(C) the health plan (and its providers) comply with legal duties and requirements under State workers compensation law; and

(D) if the health plan is unable to provide a workers compensation service needed to treat a work-related injury or illness, the injured worker is referred (in consultation with the workers compensation carrier) to an appropriate provider.

(c) ADMINISTRATION.—The Secretary of Labor shall administer this part and, for such purposes, the Secretary is authorized to prescribe such rules and regulations as may be necessary and appropriate.

SEC. 10002. PAYMENT BY WORKERS COMPENSATION CARRIER.

(a) PAYMENT.—

(1) IN GENERAL.—Each workers compensation carrier that is liable for payment for workers compensation services furnished by or through a health plan, regardless of whether or not the services are included in the comprehensive benefit package, shall make payment for such services.

(2) USE OF REGIONAL ALLIANCE FEE SCHEDULE.—Except as provided in subsection (b), such payment shall be made in accordance with the appli-

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1 cable fee schedule established under section 1322(c)
2 or section 10013.

3 (b) ALTERNATIVE PAYMENT METHODOLOGIES.—

4 Subsection (a)(2) shall not apply—

5 (1) in the case of a regional alliance or partici-
6 pating State that establishes an alternative payment
7 methodology (such as payment on a negotiated fee
8 for each case) for payment for workers compensation
9 services; or

10 (2) in the case in which a workers compensa-
11 tion carrier and the health plan negotiate alternative
12 payment arrangements.

13 (c) LIMITATION OF LIABILITY OF INJURED WORK-
14 ER.—Nothing in this part shall be construed as requiring
15 an injured worker to make any payment (including pay-
16 ment of any cost sharing or any amount in excess of the
17 applicable fee schedule) to any health plan or health care
18 provider for the receipt of workers compensation services.

19 **PART 2—REQUIREMENTS OF PARTICIPATING**
20 **STATES**

21 **SEC. 10011. COORDINATION OF SPECIALIZED WORKERS**
22 **COMPENSATION PROVIDERS.**

23 (a) IN GENERAL.—Each participating State shall co-
24 ordinate access to services provided by specialized workers
25 compensation providers on behalf of health plans, provid-

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1 ing coverage to individuals residing in the State, under
2 part 1.

3 (b) OPTIONAL DESIGNATION OF SPECIALIZED
4 WORKERS COMPENSATION PROVIDERS.—A participating
5 State may designate such specialized workers compensa-
6 tion providers, with respect to one or more types of ill-
7 nesses or injuries in a geographic area as the State deter-
8 mines to be appropriate, to provide under part 1 workers
9 compensation services that—

10 (1) are not included in the comprehensive bene-
11 fit package, or

12 (2) are so included but are specialized services
13 that are typically provided (as determined by the
14 State) by specialists in occupational or rehabilitative
15 medicine.

16 Injured workers and health plans may elect to use such
17 providers under section 10001(a)(4).

18 **SEC. 10012. PREEMPTION OF STATE LAWS RESTRICTING**
19 **DELIVERY OF WORKERS COMPENSATION**
20 **MEDICAL BENEFITS.**

21 (a) IN GENERAL.—Subject to section 10011(b), no
22 State law shall have any effect that restricts the choice,
23 or payment, of providers that may provide workers com-
24 pensation services for individuals enrolled in a health plan.

1322

1 (b) DISPUTE RESOLUTION.—A State law may pro-
2 vide for a method for resolving disputes among parties re-
3 lated to—

4 (1) an individual's entitlement to workers com-
5 pensation medical benefits under State law,

6 (2) the necessity and appropriateness of work-
7 ers compensation services provided to an injured
8 worker, and

9 (3) subject to section 10002, the reasonableness
10 of charges or fees charged for workers compensation
11 services.

12 **SEC. 10013. DEVELOPMENT OF SUPPLEMENTAL SCHEDULE.**

13 Each participating State shall develop a fee schedule
14 applicable to payment for workers compensation services
15 for which a fee is not included in the applicable fee sched-
16 ule established under section 1322(c).

17 **SEC. 10014. CONSTRUCTION.**

18 (a) IN GENERAL.—Nothing in this subtitle shall be
19 construed as altering—

20 (1) the effect of a State workers compensation
21 law as the exclusive remedy for work-related injuries
22 or illnesses,

23 (2) the determination of whether or not a per-
24 son is an injured worker and entitled to workers
25 compensation medical benefits under State law,

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(3) the scope of items and services available to injured workers entitled to workers compensation medical benefits under State law, or

(4) the eligibility of any individual or class of individuals for workers compensation medical benefits under State law.

(b) **EARLY INTEGRATION.**—Nothing in this subtitle shall prevent a State from integrating or otherwise coordinating the payment for workers compensation medical benefits with payment for benefits under health insurance or health benefit plans before the date the Commission submits its report under section 10201(e).

PART 3—APPLICATION OF INFORMATION REQUIREMENTS; REPORT ON PREMIUM REDUCTIONS

SEC. 10021. APPLICATION OF INFORMATION REQUIREMENTS.

(a) **IN GENERAL.**—The provisions of—

(1) part 3 of subtitle B of title V (relating to use of standard forms), and

(2) section 5101(e)(9) (relating to provision of data on quality),

apply to the provision of workers compensation services in the same manner as such provisions apply with respect

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1 to the provision of services included in the comprehensive
2 benefit package.

3 (b) RULES.—The Secretary of Labor shall promul-
4 gate rules to clarify the responsibilities of health plans and
5 workers compensation carriers in carrying out the provi-
6 sions referred to in subsection (a).

7 **SEC. 10022. REPORT ON REDUCTION IN WORKERS COM-**
8 **PENSATION PREMIUMS.**

9 (a) STUDY AND REPORT.—

10 (1) STUDY.—The Secretary of Labor shall pro-
11 vide for a study of the impact of the provisions of
12 this subtitle on the premium rates charged to em-
13 ployers for workers compensation insurance. Such
14 study shall use information supplied by States relat-
15 ing to workers compensation premiums and such
16 other information as such Secretary finds appro-
17 priate.

18 (2) REPORT.—Such Secretary shall submit to
19 the Congress, by not later than 2 years after the
20 date that this subtitle applies in all States, a report
21 on the findings of the study.

22 (b) WORKERS COMPENSATION CARRIER FILINGS.—

23 (1) IN GENERAL.—Within six months after the
24 date this subtitle is effective in a participating State,
25 each workers compensation carrier (other than a

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1 self-funded employer) providing workers compensa-
2 tion insurance in the State shall make a filing with
3 an agency designated by the State. Such filing shall
4 describe the manner in which such carrier has modi-
5 fied (or intends to modify) its premium rates for
6 workers compensation insurance provided in the
7 State to reflect the changes brought about by the
8 provisions in this subtitle. The filing shall include
9 such actuarial projections and assumptions as nec-
10 essary to support the modifications of such rates.

11 (2) REPORT TO SECRETARY.—Each participat-
12 ing State shall provide to the Secretary of Labor
13 such information on filings made under paragraph
14 (1) as such Secretary may specify.

15 **PART 4—DEMONSTRATION PROJECTS**

16 **SEC. 10031. AUTHORIZATION.**

17 The Secretary of Health and Human Services and the
18 Secretary of Labor are authorized to conduct demonstra-
19 tion projects under this part in one or more States with
20 respect to treatment of work-related injuries and illnesses.

21 **SEC. 10032. DEVELOPMENT OF WORK-RELATED PROTO-**

22 **COLS.**

23 (a) IN GENERAL.—Under this part, the Secretaries,
24 in consultation with States and such experts on work-re-
25 lated injuries and illnesses as the Secretaries find appro-

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1 piate, shall develop protocols for the appropriate treat-
2 ment of work-related conditions.

3 (b) TESTING OF PROTOCOLS.—The Secretaries shall
4 enter into contracts with one or more health alliances to
5 test the validity of the protocols developed under sub-
6 section (a).

7 **SEC. 10033. DEVELOPMENT OF CAPITATION PAYMENT MOD-**
8 **ELS.**

9 Under this part, the Secretaries shall develop, using
10 protocols developed under section 10032 if possible, meth-
11 ods of providing for payment by workers compensation
12 carriers to health plans on a per case, capitated payment
13 for the treatment of specified work-related injuries and ill-
14 nesses.

15 **Subtitle B—Automobile Insurance**

16 **SEC. 10100. DEFINITIONS.**

17 In this subtitle:

18 (1) INJURED INDIVIDUAL.—The term “injured
19 individual” means, with respect to a health plan, an
20 individual enrolled under the plan who has an injury
21 or illness sustained in an automobile accident for
22 which automobile insurance medical benefits are
23 available.

24 (2) AUTOMOBILE INSURANCE MEDICAL BENE-
25 FITS.—The term “automobile insurance medical

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benefits” means, with respect to an enrollee, the comprehensive medical benefits for injuries or illnesses sustained in automobile accidents.

(3) AUTOMOBILE INSURANCE CARRIER.—The term “automobile insurance carrier” means an insurance company that underwrites automobile insurance medical benefits and includes an employer or fund that is financially at risk for the provision of automobile insurance medical benefits.

(4) AUTOMOBILE INSURANCE MEDICAL SERVICES.—The term “automobile insurance medical services” means items and services included in automobile insurance medical benefits and includes items and services (such as rehabilitation services and long-term care services) commonly used for treatment of injuries and illnesses sustained in automobile accidents.

**PART 1—HEALTH PLAN REQUIREMENTS
RELATING TO AUTOMOBILE INSURANCE**

SEC. 10101. PROVISION OF AUTOMOBILE INSURANCE MEDICAL BENEFITS THROUGH HEALTH PLANS.

(a) IN GENERAL.—An individual entitled to automobile insurance medical benefits and enrolled in a health plan shall receive automobile insurance medical services

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1 through the provision (or arrangement for the provision)
2 of such services by the health plan.

3 (b) REFERRAL FOR SPECIALIZED SERVICES.—Each
4 health plan shall provide for such referral for automobile
5 insurance medical services as may be necessary to assure
6 appropriate treatment of injured individuals.

7 (c) EXCEPTIONS.—Subsections (a) and (b) shall not
8 apply in the case of an individual described in section
9 1004(b) and making an election described in such section.

10 (d) ALTERNATIVE PERMITTED.—Subsection (a) shall
11 not be construed as preventing an injured individual and
12 an automobile insurance carrier from agreeing that auto-
13 mobile insurance medical services shall be provided other
14 than by or through the health plan in which the individual
15 is enrolled.

16 **SEC. 10102. PAYMENT BY AUTOMOBILE INSURANCE CAR-**
17 **RIER.**

18 (a) PAYMENT.—

19 (1) IN GENERAL.—Except as provided in sub-
20 section (b), each automobile insurance carrier that is
21 liable for payment for automobile insurance medical
22 services furnished by or through a health plan, re-
23 gardless of whether or not the services are included
24 in the comprehensive benefit package, shall make
25 payment for such services.

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1 (2) USE OF REGIONAL ALLIANCE FEE SCHED-
2 ULE.—Such payment shall be made in accordance
3 with the applicable fee schedule established under
4 section 1322(c) or section 10111.

5 (b) ALTERNATIVE PAYMENT METHODOLOGIES.—
6 Subsection (a) shall not apply—

7 (1) in the case of a regional alliance or partici-
8 pating State that establishes an alternative payment
9 methodology (such as payment on a negotiated fee
10 for each case) for payment for automobile insurance
11 medical services; or

12 (2) in the case in which a automobile insurance
13 carrier and the health plan negotiate alternative pay-
14 ment arrangements.

15 (c) LIMITATION OF LIABILITY OF INJURED INDIVID-
16 UAL.—Nothing in this part shall be construed as requiring
17 an injured individual to make any payment (including pay-
18 ment of any cost sharing or any amount in excess of the
19 applicable fee schedule) to any health plan or health care
20 provider for the receipt of automobile insurance medical
21 services.

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1 **PART 2—REQUIREMENT OF PARTICIPATING**
2 **STATES**

3 **SEC. 10111. DEVELOPMENT OF SUPPLEMENTAL SCHEDULE.**

4 Each participating State shall develop a fee schedule
5 applicable to payment for automobile insurance medical
6 services for which a fee is not included in the applicable
7 fee schedule established under section 1322(c).

8 **SEC. 10112. CONSTRUCTION.**

9 Nothing in this subtitle shall be construed as
10 altering—

11 (1) the determination of whether or not a per-
12 son is an injured individual and entitled to auto-
13 mobile insurance medical benefits under State law,
14 or

15 (2) the scope of items and services available to
16 injured individuals entitled to automobile insurance
17 medical benefits under State law.

18 **PART 3—APPLICATION OF INFORMATION**
19 **REQUIREMENTS.**

20 **SEC. 10121. APPLICATION OF INFORMATION REQUIRE-**
21 **MENTS.**

22 (a) IN GENERAL.—The provisions of—

23 (1) part 3 of subtitle B of title V (relating to
24 use of standard forms), and

25 (2) section 5101(e)(9) (relating to provision of
26 data on quality),

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1 apply to the provision of automobile insurance medical
2 services in the same manner as such provisions apply with
3 respect to the provision of services included in the com-
4 prehensive benefit package.

5 (b) RULES.—The Secretary of Labor shall promul-
6 gate rules to clarify the responsibilities of health plans and
7 automobile insurance carriers in carrying out the provi-
8 sions referred to in subsection (a).

9 **Subtitle C—COMMISSION ON**
10 **INTEGRATION OF HEALTH**
11 **BENEFITS**

12 **SEC. 10201. COMMISSION.**

13 (a) ESTABLISHMENT.—There is hereby created a
14 Commission on Integration of Health Benefits (in this sec-
15 tion referred to as the “Commission”).

16 (b) COMPOSITION.—

17 (1) IN GENERAL.—The Commission shall con-
18 sist of 15 members appointed jointly by the Sec-
19 retary of Health and Human Services and the Sec-
20 retary of Labor.

21 (2) NO COMPENSATION EXCEPT TRAVEL EX-
22 PENSES.—Members of the Commission shall serve
23 without compensation, but the Secretaries shall pro-
24 vide that each member shall receive travel expenses,
25 including per diem in lieu of subsistence, in accord-

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1 ance with sections 5702 and 5703 of title 5, United
2 States Code.

3 (c) DUTIES.—The Commission shall study the fea-
4 sibility and appropriateness of transferring financial re-
5 sponsibility for all medical benefits (including those cur-
6 rently covered under workers compensation and auto-
7 mobile insurance) to health plans.

8 (d) STAFF SUPPORT.—The Secretaries shall provide
9 staff support for the Commission.

10 (e) REPORT.—The Commission shall submit a report
11 on its work to the President by not later than July 1,
12 1995. If such report recommends the integration of finan-
13 cial responsibility for all medical benefits in health plans,
14 such report shall provide for a detailed plan as to how
15 (and when) such an integration should be effected under
16 this Act.

17 (f) TERMINATION.—The Commission shall terminate
18 90 days after the date of submission of its report under
19 subsection (e).

20 (g) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated such sums as may be
22 necessary to carry out this section.

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Subtitle D—Federal Employees’ Compensation Act

SEC. 10301. APPLICATION OF POLICY.

(a) IN GENERAL.—Chapter 81 of title 5, United States Code, known as the Federal Employees’ Compensation Act shall be interpreted and administered consistent with the provisions of subtitle A.

(b) CONSTRUCTION.—In applying subsection (a), subtitle A shall be applied as if the following modifications had been made in subtitle A:

(1) Any reference in section 10000, section 10001(c)(2)(C), section 10012(b), or section 10014 to a State law is deemed to include a reference to chapter 81 of title 5, United States Code.

(2) The term “workers compensation carrier” includes the Employees Compensation Fund (established under section 8147 of title 5, United States Code).

Subtitle E—Davis-Bacon Act and Service Contract Act

SEC. 10401. COVERAGE OF BENEFITS UNDER HEALTH SECURITY ACT.

(a) DAVIS-BACON ACT.—Subsection (b)(2) of the first section of the Davis Bacon Act (40 U.S.C. 276a(b)(2)) is amended in the matter following subpara-

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1 graph (B) by inserting after “local law” the following:
2 “(other than benefits provided pursuant to the Health Se-
3 curity Act)”.

4 (b) SERVICE CONTRACT ACT OF 1965.—The second
5 sentence of section 2(a)(2) of the Service Contract Act of
6 1965 (41 U.S.C. 351(a)(2)) is amended by inserting after
7 “local law” the following: “(other than benefits provided
8 pursuant to the Health Security Act)”.

9 Subtitle F—Effective Dates

10 SEC. 10501. REGIONAL ALLIANCES.

11 The provisions of subtitles A and B of this title apply
12 to regional alliances, and regional alliance health plans,
13 in a State 2 years after the State’s first year (as defined
14 in section 1902(17)).

15 SEC. 10502. CORPORATE ALLIANCES.

16 The provisions of subtitles A and B of this title apply
17 to corporate alliances, and corporate alliance health plans,
18 on the date under section 10501 that such subtitles apply
19 to regional alliances, and regional alliance health plans,
20 in the State.

21 SEC. 10503. FEDERAL REQUIREMENTS.

22 The provisions of subtitle D of this title shall take
23 effect on January 1, 1998.

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TITLE XI—TRANSITIONAL INSURANCE REFORM

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3 SEC. 11001. IMPOSITION OF REQUIREMENTS.

4 (a) IN GENERAL.—The Secretary and the Secretary
5 of Labor shall apply the provisions of this title to assure,
6 to the extent possible, the maintenance of current health
7 care coverage and benefits during the period between the
8 enactment of this Act and the dates its provisions are im-
9 plemented in the various States.

10 (b) ENFORCEMENT.—

11 (1) HEALTH INSURANCE PLANS.—The Sec-
12 retary shall enforce the requirements of this title
13 with respect to health insurance plans. The Sec-
14 retary shall promulgate regulations to carry out the
15 requirements under this title with respect to health
16 insurance plans. The Secretary shall promulgate reg-
17 ulations with respect to section 11004 within 90
18 days after the date of the enactment of this Act.

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1 (2) SELF-INSURED PLANS.—The Secretary of
2 Labor shall enforce the requirements of this title
3 with respect to self-insured plans. Such Secretary
4 shall promulgate regulations to carry out the re-
5 quirements under this title as they relate to self-
6 funded plans.

7 (3) ARRANGEMENTS WITH STATES.—The Sec-
8 retary and the Secretary of Labor may enter into ar-
9 rangements with a State to enforce the requirements
10 of this title with respect to health insurance plans
11 and self-insured plans issued or sold, or established
12 and maintained, in the State.

13 (c) PREEMPTION.—The requirements of this title do
14 not preempt any State law unless State law directly con-
15 flicts with such requirements. The provision of additional
16 protections under State law shall not be considered to di-
17 rectly conflict with such requirements. The Secretary (or,
18 in the case of a self-insured plan, the Secretary of Labor)
19 may issue letter determinations with respect to whether
20 this Act preempts a provision of State law.

21 (d) INTERIM FINAL REGULATIONS.—Section 1911
22 shall apply to regulations issued to carry out this title.
23 The Secretary may consult with States and the National
24 Association of Insurance Commissioners in issuing regula-
25 tions and guidelines under this title.

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1 (e) CONSTRUCTION.—The provisions of this title shall
2 be construed in a manner that assures, to the greatest
3 extent practicable, continuity of health benefits under
4 health benefit plans in effect on the effective date of this
5 Act.

6 (f) SPECIAL RULES FOR ACQUISITIONS AND TRANS-
7 FERS.—The Secretary may issue regulations regarding the
8 application of this title in the case of health insurance
9 plans (or groups of such plans) which are transferred from
10 one insurer to another insurer through assumption, acqui-
11 sition, or otherwise.

12 SEC. 11002. ENFORCEMENT.

13 (a) IN GENERAL.—Any health insurer or health bene-
14 fit plan sponsor that violates a requirement of this title
15 shall be subject to a civil money penalty of not more than
16 \$25,000 for each such violation. The provisions of section
17 1128A of the Social Security Act (other than subsections
18 (a) and (b)) shall apply to civil money penalties under this
19 subsection in the same manner as they apply to a penalty
20 or proceeding under section 1128A(a) of such Act.

21 (b) EQUITABLE REMEDIES.—

22 (1) IN GENERAL.—A civil action may be
23 brought by the applicable Secretary—

24 (A) to enjoin any act or practice which vio-
25 lates any provision of this title, or

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1 (B) to obtain other appropriate equitable
2 relief (i) to redress such violations, or (ii) to en-
3 force any provision of this title, including, in
4 the case of a wrongful termination of (or re-
5 fusal to renew) coverage, reinstating coverage
6 effective as of the date of the violation.

7 **SEC. 11003. REQUIREMENTS RELATING TO PRESERVING**
8 **CURRENT COVERAGE.**

9 (a) **PROHIBITION OF TERMINATION.—**

10 (1) **GROUP HEALTH INSURANCE PLANS.—**Each
11 health insurer that provides a group health insur-
12 ance plan may not terminate (or fail to renew) cov-
13 erage for any covered employee if the employer of
14 the employee continues the plan, except in the case
15 of—

16 (A) nonpayment of required premiums,

17 (B) fraud, or

18 (C) misrepresentation of a material fact re-
19 lating to an application for coverage or claim
20 for benefits.

21 (2) **INDIVIDUAL HEALTH INSURANCE PLANS.—**

22 Each health insurer that provides coverage to a cov-
23 ered individual under an individual health insurance
24 plan may not terminate (or fail to renew) coverage

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1 for such individual (or a covered dependent), except
2 in the case of—

3 (A) nonpayment of required premiums,

4 (B) fraud, or

5 (C) misrepresentation of a material fact re-
6 lating to an application for coverage or claim
7 for benefits.

8 (2) EFFECTIVE DATE OF TITLE.—

9 (A) IN GENERAL.—This subsection shall
10 take effect on the effective date of this title and
11 shall apply to coverage on or after such date.

12 (B) DEFINITION.—Except as otherwise
13 provided, in this title the term “effective date of
14 this title” means the date of the enactment of
15 this Act.

16 (b) ACCEPTANCE OF NEW MEMBERS IN A GROUP
17 HEALTH INSURANCE PLAN.—

18 (1) IN GENERAL.—In the case of a health in-
19 surer that provides a group health insurance plan
20 that is in effect on the effective date of this title, the
21 insurer is required—

22 (A) to accept all individuals, and their eli-
23 gible dependents, who become full-time employ-
24 ees (as defined in section 1901(b)(2)(C)) of an
25 employer covered after such effective date;

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1 (B) to establish and apply premium rates
2 that are consistent with section 11004(b); and
3 (C) to limit the application of pre-existing
4 condition restrictions in accordance with section
5 11005.

6 (2) CONSISTENT APPLICATION OF RULES RE-
7 LATING TO DEPENDENTS AND WAITING PERIODS.—
8 In this subsection, the term “eligible dependent”,
9 with respect to a group health insurance plan, has
10 the meaning provided under the plan as of October
11 27, 1993, or, in the case of a plan not established
12 as of such date, as of the date of establishment of
13 the plan.

14 **SEC. 11004. RESTRICTIONS ON PREMIUM INCREASES DUR-**
15 **ING TRANSITION.**

16 (a) DIVISION OF HEALTH INSURANCE PLANS BY
17 SECTOR.—For purposes of this section, each health in-
18 surer shall divide its health insurance business into the
19 following 3 sectors:

20 (1) Health insurance for groups with at least
21 100 covered lives (in this section referred to as the
22 “large group sector”)

23 (2) Health insurance for groups with fewer
24 than 100 covered lives (in this section referred as
25 the “small group sector”).

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1 (3) Health insurance for individuals, and not
2 for groups (in this section referred to as the “indi-
3 vidual sector”).

4 (b) PREMIUM CHANGES TO REFLECT CHANGES IN
5 GROUP OR INDIVIDUAL CHARACTERISTICS OR TERMS OF
6 COVERAGE.—

7 (1) APPLICATION.—The provisions of this sub-
8 section shall apply to changes in premiums that
9 reflect—

10 (A) changes in the number of individuals
11 covered under a plan;

12 (B) changes in the group or individual
13 characteristics (including age, gender, family
14 composition or geographic area but not includ-
15 ing health status, claims experience or duration
16 of coverage under the plan) of individuals cov-
17 ered under a plan;

18 (C) changes in the level of benefits (includ-
19 ing changes in cost-sharing) under the plan;
20 and

21 (D) changes in any material terms and
22 conditions of the health insurance plan (other
23 than factors related to health status, claims ex-
24 perience, and duration of coverage under the
25 plan).

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1 (2) SPECIFICATION OF REFERENCE RATE FOR
2 EACH SECTOR.—Each health insurer shall calculate
3 a reference rate for each such sector. The reference
4 rate for a sector shall be calculated so that, if it
5 were applied using the rate factors specified under
6 paragraph (3), the average premium rate for individ-
7 uals and groups in that sector would approximate
8 the average premium rate charged individuals and
9 groups in the sector as of the effective date of this
10 title.

11 (3) SINGLE SET OF RATE FACTORS WITHIN
12 EACH SECTOR.—

13 (A) IN GENERAL.—Each health insurer
14 shall develop for each sector a single set of rate
15 factors which will be used to calculate any
16 changes in premium that relate to the reasons
17 described in subparagraphs (B) through (D) of
18 paragraph (1).

19 (B) STANDARDS.—Such rate factors—

20 (i) shall relate to reasonable and ob-
21 jective differences in demographic charac-
22 teristics, in the design and in levels of cov-
23 erage, and in other terms and conditions of
24 a contract,

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1 (ii) shall not relate to expected health
2 status, claims experience, or duration of
3 coverage of the one or more groups or indi-
4 viduals, and

5 (iii) shall comply with regulations es-
6 tablished under subsection (f).

7 (4) COMPUTATION OF PREMIUM CHANGES.—

8 (A) IN GENERAL.—Changes in premium
9 rates that relate to the reasons described in
10 paragraph (1) shall be calculated using the rate
11 factors developed pursuant to paragraph (3).

12 (B) APPLICATION TO CHANGES IN NUMBER
13 OF COVERED INDIVIDUALS.—In the case of a
14 change in premium rates related to the reason
15 described in paragraph (1)(A), the change in
16 premium rates shall be calculated to reflect,
17 with respect to the enrollees who enroll or
18 disenroll in a health insurance plan, the sum of
19 the products, for such individuals, of the ref-
20 erence rate (determined under paragraph (2))
21 and the rate factors (specified under paragraph
22 (3)) applicable to such enrollees.

23 (C) APPLICATION OF OTHER FACTORS.—

24 (i) IN GENERAL.—In the case of a
25 change in premium rates related to a rea-

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1 son described in subparagraph (B), (C), or
2 (D) of paragraph (1), the change in pre-
3 mium rates with respect to each health in-
4 surance plan in each sector shall reflect the
5 rate factors specified under paragraph (3)
6 applicable to the reason as applied to the
7 current premium charged for the health in-
8 surance plan. Such rate factors shall be
9 applied in a manner so that the resulting
10 adjustment, to the extent possible, reflects
11 the premium that would have been charged
12 under the plan if the reason for the change
13 in premium had existed at the time that
14 the current premium rate was calculated.

15 (ii) NO REFLECTION OF CHANGE IN
16 HEALTH STATUS.—In applying the rate
17 factors under this subparagraph, the ad-
18 justment shall not reflect any change in
19 the health status, claims experience or du-
20 ration of coverage with respect to any em-
21 ployer or individual covered under the
22 plan.

23 (5) LIMITATION ON APPLICATION.—This sub-
24 section shall only apply—

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(A) to changes in premiums occurring on or after the date of the enactment of this Act to groups and individuals covered as of such date, and .

(B) with respect to groups and individuals subsequently covered, to changes in premiums subsequent to such coverage.

(6) APPLICATION TO COMMUNITY-RATED PLANS.—Nothing in this subsection shall require the application of rate factors related to individual or group characteristics with respect to community-rated plans.

(c) LIMITATIONS ON CHANGES IN PREMIUMS RELATED TO INCREASES IN HEALTH CARE COSTS AND UTILIZATION.—

(1) APPLICATION.—The provisions of this subsection shall apply to changes in premiums that reflect increases in health care costs and utilization.

(2) EQUAL INCREASE FOR ALL PLANS IN ALL SECTORS.—

(A) IN GENERAL.—Subject to subparagraph (B), the annual percentage increase in premiums by a health insurer for health insurance plans in the individual sector, small group sector, and large group sector, to the extent

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1 such increase reflect increases in health care
2 costs and utilization, shall be the same for all
3 such plans in those sectors.

4 (B) SPECIAL RULE FOR LARGE GROUP
5 SECTOR.—The annual percentage increase in
6 premiums by a health insurer for health insur-
7 ance plans in the large group sector may vary
8 among such plans based on the claims experi-
9 ence of an employer (to the extent the experi-
10 ence is credible), so long as the weighted aver-
11 age of such increases for all such plans in the
12 sector complies with the requirement of sub-
13 paragraph (A).

14 (C) GEOGRAPHIC APPLICATION.—Subpara-
15 graphs (A) and (B)—

16 (i) may be applied on a national level,
17 or

18 (ii) may vary based on geographic
19 area, but only if (I) such areas are suffi-
20 ciently large to provide credible data on
21 which to calculate the variation and (II)
22 the variation is due to reasonable factors
23 related to the objective differences among
24 such areas in costs and utilization of
25 health services.

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(D) EXCEPTIONS TO ACCOMMODATE STATE RATE REFORM EFFORTS.—Subparagraphs (A) and (B) shall not apply, in accordance with guidelines of the Secretary, to the extent necessary to permit a State to narrow the variations in premiums among health insurance plans offered by health insurers to similarly situated groups or individuals within a sector.

(E) EXCEPTION FOR RATES SUBJECT TO PRIOR APPROVAL.—Subparagraphs (A) and (B) shall not apply to premiums that are subject to prior approval by a State insurance commissioner (or similar official) and are approved by such official.

(F) OTHER REASONS SPECIFIED BY THE SECRETARY.—The Secretary may specify through regulations such other exceptions to the provisions of this subsection as the Secretary determines are required to enhance stability of the health insurance market and continued availability of coverage.

(3) EVEN APPLICATION THROUGHOUT A YEAR.—In applying the provisions of this subsection to health insurance plans that are renewed in different months of a year, the annual percentage in-

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1 crease shall be applied in a consistent, even manner
2 so that any variations in the rate of increase applied
3 in consecutive months are even and continuous dur-
4 ing the year.

5 (4) PETITION FOR EXCEPTION.—A health in-
6 surer may petition the Secretary (or a State acting
7 under a contract with the Secretary under section
8 11001(b)(3)) for an exception from the application
9 of the provisions of this subsection. The Secretary
10 may approve such an exception if—

11 (A) the health insurer demonstrates that
12 the application of this subsection would threat-
13 en the financial viability of the insurer, and

14 (B) the health insurer offers an alternative
15 method for increasing premiums that is not
16 substantially discriminatory to any sector or to
17 any group or individual covered by a health in-
18 surance plan offered by the insurer.

19 (d) PRIOR APPROVAL FOR CERTAIN RATE IN-
20 CREASES.—

21 (1) IN GENERAL.—If the percentage increase in
22 the premium rate for the individual and small group
23 sector exceeds a percentage specified by the Sec-
24 retary under paragraph (2), annualized over any 12-
25 month period, the increase shall not take effect un-

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1 less the Secretary (or a State acting under a con-
2 tract with the Secretary under section 11001(b)(3))
3 has approved the increase.

4 (2) PERCENTAGE.—The Secretary shall specify,
5 for each 12-month period beginning after the date of
6 the enactment of this Act, a percentage that will
7 apply under paragraph (1). Such percentage shall be
8 determined taking into consideration the rate of in-
9 crease in health care costs and utilization, previous
10 trends in health insurance premiums, and the condi-
11 tions in the health insurance market. Within 30 days
12 after the date of the enactment of this Act, the Sec-
13 retary shall first specify a percentage under this
14 paragraph.

15 (e) DOCUMENTATION OF COMPLIANCE.—

16 (1) PERIOD FOR CONFORMANCE.—Effective 1
17 year after the date of the enactment of this Act, the
18 premium for each health insurance plan shall be
19 conformed in a manner that complies with the provi-
20 sions of this section.

21 (2) METHODOLOGY.—Each health insurer shall
22 document the methodology used in applying sub-
23 sections (b) and (c) with respect to each sector (and
24 each applicable health plan). Such documentation
25 shall be sufficient to permit the auditing of the ap-

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1 plication of such methodology to determine if such
2 application was consistent with such subsections.

3 (3) CERTIFICATION.—For each 6-month period
4 in which this section is effective, each health insurer
5 shall file a certification with the Secretary (or with
6 a State with which the Secretary has entered into an
7 arrangement under section 11001(b)(3)) that the in-
8 surer is in compliance with such requirements.

9 (f) REGULATIONS.—The Secretary shall establish
10 regulations to carry out this section. Such regulations may
11 include guidelines relating to the permissible variation
12 that results from the use of demographic or other charac-
13 teristics in the development of rate factors. Such guide-
14 lines may be based on the guidelines currently used by
15 States in applying rate limitations under State insurance
16 regulations.

17 (g) EFFECTIVE PERIOD.—This section shall apply to
18 premium increases occurring during the period beginning
19 on the date of the enactment of this Act and ending, for
20 a health insurance plan provided in a State, on the first
21 day of the State's first year.

22 **SEC. 11005. REQUIREMENTS RELATING TO PORTABILITY.**

23 (a) TREATMENT OF PREEXISTING CONDITION EX-
24 CLUSIONS.—

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1 (1) IN GENERAL.—Subject to the succeeding
2 provisions of this subsection, a group health benefit
3 plan may exclude coverage with respect to services
4 related to treatment of a preexisting condition, but
5 the period of such exclusion may not exceed 6
6 months. The exclusion of coverage shall not apply to
7 services furnished to newborns or in the case of a
8 plan that did not apply such exclusions as of the ef-
9 fective date of this title.

10 (2) CREDITING OF PREVIOUS COVERAGE.—

11 (A) IN GENERAL.—A group health benefit
12 plan shall provide that if an individual covered
13 under such plan is in a period of continuous
14 coverage (as defined in subparagraph (B)(i))
15 with respect to particular services as of the date
16 of initial coverage under such plan, any period
17 of exclusion of coverage with respect to a pre-
18 existing condition for such services or type of
19 services shall be reduced by 1 month for each
20 month in the period of continuous coverage.

21 (B) DEFINITIONS.—As used in this para-
22 graph:

23 (i) PERIOD OF CONTINUOUS COV-
24 ERAGE.—The term “period of continuous
25 coverage” means, with respect to particu-

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1 lar services, the period beginning on the
2 date an individual is enrolled under a
3 group or individual health benefit plan,
4 self-insured plan, the medicare program, a
5 State medicaid plan, or other health bene-
6 fit arrangement which provides benefits
7 with respect to such services and ends on
8 the date the individual is not so enrolled
9 for a continuous period of more than 3
10 months.

11 (ii) PREEXISTING CONDITION.—The
12 term “preexisting condition” means, with
13 respect to coverage under a health benefits
14 plan, a condition which has been diagnosed
15 or treated during the 6-month period end-
16 ing on the day before the first date of such
17 coverage (without regard to any waiting
18 period).

19 (b) WAITING PERIODS.—A self-insured plan, and an
20 employer with respect to a group health insurance plan,
21 may not discriminate among employees in the establish-
22 ment of a waiting period before making health insurance
23 coverage available based on the health status, claims expe-
24 rience, receipt of health care, medical history, or lack of

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1 evidence of insurability, of the employee or the employee's
2 dependents.

3 **SEC. 11006. REQUIREMENTS LIMITING REDUCTION OF BEN-**
4 **EFITS.**

5 (a) IN GENERAL.—A self-insured sponsor may not
6 make a modification of benefits described in subsection
7 (b).

8 (b) MODIFICATION OF BENEFITS DESCRIBED.—

9 (1) IN GENERAL.—A modification of benefits
10 described in this subsection is any reduction or limi-
11 tation in coverage, effected on or after the effective
12 date of this title, with respect to any medical condi-
13 tion or course of treatment for which the anticipated
14 cost is likely to exceed \$5,000 in any 12-month pe-
15 riod.

16 (2) TREATMENT OF TERMINATION.—A modi-
17 fication of benefits includes the termination of a
18 plan if the sponsor, within a period (specified by the
19 Secretary of Labor) establishes a substitute plan
20 that reflects the reduction or limitation described in
21 paragraph (1).

22 (c) REMEDY.—Any modification made in violation of
23 this section shall not be effective and the self-insured
24 sponsor shall continue to provide benefits as though the

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1 modification (described in subsection (b)) had not oc-
2 curred.

3 **SEC. 11007. NATIONAL TRANSITIONAL HEALTH INSURANCE**

4 **RISK POOL.**

5 (a) **ESTABLISHMENT.**—In order to assure access to
6 health insurance during the transition, the Secretary is
7 authorized to establish a National Transitional Health In-
8 surance Risk Pool (in this section referred to as the “na-
9 tional risk pool”) in accordance with this section.

10 (b) **ADMINISTRATION.**—

11 (1) **IN GENERAL.**—The Secretary may admin-
12 ister the national risk pool through contracts with—

13 (A) one or more existing State health in-
14 surance risk pools,

15 (B) one or more private health insurers, or

16 (C) such other contracts as the Secretary
17 deems appropriate.

18 (2) **COORDINATION WITH STATE RISK POOLS.**—

19 The Secretary may enter into such arrangements
20 with existing State health insurance risk pools to co-
21 ordinate the coverage under such pools with the cov-
22 erage under the national risk pool. Such coordina-
23 tion may address eligibility and funding of coverage
24 for individuals currently covered under State risk
25 pools.

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1 (c) ELIGIBILITY FOR COVERAGE.—The national risk
2 pool shall provide health insurance coverage to individuals
3 who are unable to secure health insurance coverage from
4 private health insurers because of their health status or
5 condition (as determined in accordance with rules and pro-
6 cedures specified by the Secretary).

7 (d) BENEFITS.—

8 (1) IN GENERAL.—Benefits and terms of cov-
9 erage provided through the national risk pool shall
10 include items and services, conditions of coverage,
11 and cost sharing (subject to out-of-pocket limits on
12 cost sharing) comparable to the benefits and terms
13 of coverage available in State health insurance risk
14 pools.

15 (2) PAYMENT RATES.—Payments under the na-
16 tional risk pool for covered items and services shall
17 be made at rates (specified by the Secretary) based
18 on payment rates for comparable items and services
19 under the medicare program. Providers who accept
20 payment from the national risk pool shall accept
21 such payment as payment in full for the service,
22 other than for cost sharing provided under the na-
23 tional risk pool.

24 (e) PREMIUMS.—

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1 (1) IN GENERAL.—Premiums for coverage in
2 the national risk pool shall be set in a manner speci-
3 fied by the Secretary.

4 (2) VARIATION.—Such premiums shall vary
5 based upon age, place of residence, and other tradi-
6 tional underwriting factors other than on the basis
7 of health status or claims experience.

8 (3) LIMITATION.—The premiums charged indi-
9 viduals shall be set at a level that is no less than
10 150 percent of the premiums that the Secretary esti-
11 mates would be charged to a population of average
12 risk for the covered benefits.

13 (f) TREATMENT OF SHORTFALLS.—

14 (1) ESTIMATES.—The Secretary shall estimate
15 each year the extent to which the total premiums
16 collected under subsection (e) in the year are insuffi-
17 cient to cover the expenses of the national risk pool
18 with respect to the year.

19 (2) TEMPORARY BORROWING AUTHORITY.—The
20 Secretary of the Treasury is authorized to advance
21 to the Secretary amounts sufficient to cover the
22 amount estimated under paragraph (1) during the
23 year before assessments are collected under para-
24 graph (3), except that the total balance of such
25 Treasury advances at any time shall not exceed

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1 \$1,500,000,000. The Secretary shall repay such
2 amounts, with interest at a rate specified by the Sec-
3 retary of the Treasury, from the assessments under
4 paragraph (3).

5 (3) ASSESSMENTS.—

6 (A) IN GENERAL.—Each health benefit
7 plan sponsor shall be liable for an assessment
8 in the amount specified in subparagraph (C).

9 (B) AMOUNT.—For each year for which
10 amounts are advanced under paragraph (2), the
11 Secretary shall—

12 (i) estimate the total amount of pre-
13 miums (and premium equivalents) for
14 health benefits under health benefit plans
15 for the succeeding year, and

16 (ii) calculate a percentage equal to (I)
17 the total amounts repayable by the Sec-
18 retary to the Secretary of the Treasury
19 under paragraph (2) for the year, divided
20 by the amount determined under clause (i).

21 (C) ASSESSMENT AMOUNT.—The amount
22 of an assessment for a sponsor of a health ben-
23 efit plan for a year shall be equal to the per-
24 centage calculated under subparagraph (B)(ii)
25 (or, if less, $\frac{1}{2}$ of 1 percent) of the total amount

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1 of premiums (and premium equivalents) for
2 health benefits under the plan for the previous
3 year.

4 (D) SELF-INSURED PLANS.—The amount
5 of premiums (and premium equivalents) under
6 this paragraph shall be estimated—

7 (i) by the Secretary for health insur-
8 ance plans, and

9 (ii) by the Secretary of Labor for self-
10 insured plans.

11 Such estimates may be based on a methodology
12 that requires plans liable for assessment to file
13 information with the applicable Secretary.

14 **SEC. 11008. DEFINITIONS.**

15 In this title:

16 (1) APPLICABLE SECRETARY.—The term “ap-
17 plicable Secretary” means—

18 (A) the Secretary with respect to health in-
19 surance plans and insurers, or

20 (B) the Secretary of Labor with respect to
21 self-insured plans and self-insured plan spon-
22 sors.

23 (2) COVERED EMPLOYEE.—The term “covered
24 employee” means an employee (or dependent of such

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1 an employee) covered under a group health benefits
2 plan.

3 (3) COVERED INDIVIDUAL.—The “covered indi-
4 vidual” means, with respect to a health benefit plan,
5 an individual insured, enrolled, eligible for benefits,
6 or otherwise covered under the plan.

7 (4) GROUP HEALTH BENEFITS PLAN.—The
8 term “group health benefits plan” means a group
9 health insurance plan and a self-insured plan.

10 (5) GROUP HEALTH INSURANCE PLAN.—

11 (A) IN GENERAL.—The term “group
12 health insurance plan” means a health insur-
13 ance plan offered primarily to employers for the
14 purpose of providing health insurance to the
15 employees (and dependents) of the employer.

16 (B) INCLUSION OF ASSOCIATION PLANS
17 AND MEWAS.—Such term includes—

18 (i) any arrangement in which coverage
19 for health benefits is offered to employers
20 through an association, trust, or other ar-
21 rangement, and

22 (ii) a multiple employer welfare ar-
23 rangement (as defined in section 3(40) of
24 the Employee Retirement Income Security

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1 Act of 1974), whether funded through in-
2 surance or otherwise.

3 (6) HEALTH BENEFITS PLAN.—The term
4 “health benefits plan” means health insurance plan
5 and a self-insured health benefit plan.

6 (7) HEALTH BENEFIT PLAN SPONSOR.—The
7 term “health benefit plan sponsor” means, with re-
8 spect to a health insurance plan or self-insured plan,
9 the insurer offering the plan or the self-insured
10 sponsor for the plan, respectively.

11 (8) HEALTH INSURANCE PLAN.—

12 (A) IN GENERAL.—Except as provided in
13 subparagraph (B), the term “health insurance
14 plan” means any contract of health insurance,
15 including any hospital or medical service policy
16 or certificate, any major medical policy or cer-
17 tificate, any hospital or medical service plan
18 contract, or health maintenance organization
19 subscriber contract offered by an insurer.

20 (B) EXCEPTION.—Such term does not in-
21 clude any of the following—

22 (i) coverage only for accident, dental,
23 vision, disability income, or long-term care
24 insurance, or any combination thereof,

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(ii) medicare supplemental health insurance,

(iii) coverage issued as a supplement to liability insurance,

(iv) worker's compensation or similar insurance, or

(v) automobile medical payment insurance,

or any combination thereof.

(C) STOP LOSS INSURANCE NOT COVERED.—Such term does not include any aggregate or specific stop-loss insurance or similar coverage applicable to a self-insured plan. The Secretary may develop rules determining the applicability of this subparagraph with respect to minimum premium plans or other partially insured plans.

(9) HEALTH INSURER.—The term “health insurer” means a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, or other entity providing a plan of health insurance or health benefits with respect to which the State insurance laws are not preempted under section 514 of the Employee Retirement Income Security Act of 1974.

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1 (10) INDIVIDUAL HEALTH INSURANCE PLAN.—

2 (A) IN GENERAL.—The term “individual
3 health insurance plan” means any health insur-
4 ance plan directly purchased by an individual or
5 offered primarily to individuals (including fami-
6 lies) for the purpose of permitting individuals
7 (without regard to an employer contribution) to
8 purchase health insurance coverage.

9 (B) INCLUSION OF ASSOCIATION PLANS.—
10 Such term includes any arrangement in which
11 coverage for health benefits is offered to indi-
12 viduals through an association, trust, list-billing
13 arrangement, or other arrangement in which
14 the individual purchaser is primarily responsible
15 for the payment of any premium associated
16 with the contract.

17 (C) TREATMENT OF CERTAIN ASSOCIATION
18 PLANS.—In the case of a health insurance plan
19 sponsored by an association, trust, or other ar-
20 rangement that provides health insurance cov-
21 erage both to employers and to individuals, the
22 plan shall be treated as—

23 (i) a group health insurance plan with
24 respect to such employers, and

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1 (ii) an individual health insurance
2 plan with respect to such individuals.

3 (11) SELF-INSURED PLAN.—The term “self-in-
4 sured plan” means an employee welfare benefit plan
5 or other arrangement insofar as the plan or arrange-
6 ment provides benefits with respect to some or all of
7 the items and services included in the comprehensive
8 benefit package (as in effect as of January 1, 1996)
9 that is funded in a manner other than through the
10 purchase of one or more health insurance plans.
11 Such term shall not include a group health insur-
12 ance plan described in paragraph (5)(B)(ii).

13 (12) SELF-INSURED SPONSOR.—The term “self-
14 insured sponsor” includes, with respect to a self-in-
15 sured plan, any entity which establishes or main-
16 tains the plan.

17 (13) STATE COMMISSIONER OF INSURANCE.—
18 The term “State commissioner of insurance” in-
19 cludes a State superintendent of insurance.

20 **SEC. 11009. TERMINATION.**

21 (a) HEALTH INSURANCE PLANS.—The provisions of
22 this title shall not apply to a health insurance plan pro-
23 vided in a State on and after the first day of the first
24 year for the State.

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1 (b) SELF-INSURED PLANS.—The provisions of this
2 title shall not apply to a self-insured plan that—

3 (1) is sponsored by a sponsor that is an eligible
4 sponsor of a corporate alliance (described in section
5 1311(b)(1)), as of the effective date of the election
6 under section 1312(c); and

7 (2) is sponsored by a sponsor that is not such
8 an eligible sponsor, with respect to individuals or
9 groups in a State on and after the first day of the
10 first year for the State.

○

Mrs. COLLINS. Our first witness today is Mr. Gary Claxton, who is with the HHS, Office of Assistant Secretary for Legislation. You may begin at this time, Mr. Claxton.

STATEMENTS OF GARY CLAXTON, OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. CLAXTON. Thank you, Madam Chairwoman, and Mr. Stearns, for the opportunity to testify for you today regarding the provisions of the President's Health Security Act related to workers' compensation, automobile insurance, and the transition insurance reform rules.

I would like to first address the transition insurance provisions that are contained in title XI of the Health Security Act. An orderly transition to a reformed health care system is critical to any success of any type of health insurance or health care reform.

The President's plan envisions a State-by-State phase-in of reform with certain transitional insurance issues to protect employees and families during that interim period. When fully implemented, the Health Security Act will dramatically change the way the insurance market works, shifting the focus of competition away from risk selection and toward competition over quality and service. These dramatic changes, however, may cause some insurance problems during an interim period as insurers position themselves to better compete in a new health care system.

These problems could include things such as excessive rate increases and loss of coverage for certain groups of individuals, especially those with higher claims histories or poorer health status.

To protect against these problems the act contains a series of transitional insurance reforms. In general, these reforms would: First, prohibit health insurers from terminating or failing to renew coverage for any group or individual, except in cases of nonpayment, fraud, or misrepresentation; second, require insurers to cover new employees of a covered employer regardless of health status; third, limit exclusions for preexisting conditions; fourth, prohibit self-insured health plans from arbitrarily reducing benefits for high cost illnesses such as AIDS or other high cost illnesses; fifth, require insurers to apply the same level of premium increase to all covered groups and individuals; and sixth, require insurers to obtain prior approval for premium increases that exceed a threshold percentage established by the Secretary.

In addition to providing a backup mechanism to ensure coverage availability during the transition, the Secretary is authorized to create a transitional health insurance risk pool to provide coverage to individuals who are unable to obtain coverage in the private market because of their health status.

I would next like to briefly discuss the provisions of title X of the act which relate to workers' compensation and automobile insurance. Title X of the Health Security Act sets forth the framework to consider the potential integration of workers' compensation and automobile health insurance benefits into a reformed health care system.

As a first step, the Health Security Act calls for coordination of the delivery of health care services. Injured workers covered by

workers' compensation and injury victims covered by auto insurance would receive health care services they need from the health plan in which they are enrolled under health care reform. Existing payers, workers' compensation insurers and automobile insurers, would remain financially responsible for the costs of that care. Any kind of rating that exists now, including experience rating, would continue on into this phase of the new system.

As the second step, the act creates a commission to study the feasibility of integrating the financing of workers' compensation and automobile insurance benefits into a reformed health care system. Many people believe that financial integration of these two systems could improve efficiency and the commission was recommended to consider all of the various implications of doing a financial integration.

To comply with the coordination provisions of title X, each State would need to amend its compensation and automobile insurance systems as a condition of being certified by the National Health Board. In general, the coordinated provisions of the act call for, one, injured workers and injury victims to receive medical benefits—I am sorry—to receive their medical services for workers' compensation and automobile insurance, health benefits, through the health plan they use for their normal health care.

To be certified, health plans that use participating providers would need to make sure that they had the appropriate specialists to treat work-related illnesses and injuries and also automobile accidents.

Second, health plans would be reimbursed for providing services to injury victims and to injured workers by the payers who are now responsible in the system, either self-funded workers' compensation insurers, or workers' comp insurers or automobile insurance companies.

In general, the payment they would make would be on the same level as payments in the fee-for-service part of the new health care system, so it would be based on the fee-for-service fee schedule in each regional health alliance.

To assure that there is a coordination of back-to-work in the case of workers compensation, each health plan would be required to have a workers' compensation case manager. The case manager is responsible for working with employers and workers' compensation carriers to develop appropriate medical treatment and rehabilitation plans that will provide for return to work as soon as medically appropriate. The case manager also will assure that the health plan complies with the legal requirements under workers' compensation.

Finally, the provisions of the quality management administrative simplification provisions of the Health Security Act would also apply to workers' compensation and automobile insurance health benefits. In conclusion, let me state that the provisions of title X and title XI are intended to provide workable frameworks for considering these two important issues.

Any type of insurance reform that we do is going to require a set of protections for individuals as we move from one system to the next. In the case of certain State reform efforts, we have run into situations where people have lost coverage prior to the implementa-

tion of those reforms. And we need to make sure that health care reform doesn't mean lapses of coverage during this transition period.

In the case of workers' compensation and automobile insurance, we have tried to provide a workable framework for people to consider the integration of these issues. We look forward to working with members of the subcommittee and other interested parties in achieving these goals. Thank you.

[Testimony resumes on p. 88.]

[The prepared statement and responses to post-hearing questions of Mr. Claxton follow:]

STATEMENT OF
GARY CLAXTON
OFFICE OF ASSISTANT SECRETARY FOR
PLANNING AND EVALUATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Thank you Madame Chairman and members of the Subcommittee for the opportunity to testify before you today regarding the provisions in the President's Health Security Act related to the period of transition to a reformed system and coordination with workers compensation and automobile insurance.

TRANSITION TO A REFORMED SYSTEM

As you know, an orderly transition to a reformed health care system is critical to the success of any reform effort. The President's plan envisions a state-by-state phase-in of reform, with certain transitional insurance rules to protect employers and families in the interim.

I would like to lay out briefly for you the phase-in schedule under the Health Security Act. I will then outline the specific, transitional insurance reforms the President is proposing.

Phase-In Schedule

The Health Security Act envisions phasing in health care reform on a state-by-state basis, which we have found to be the most orderly approach for implementing the proposed federal-state partnership for reform.

Following enactment of the Act, the Department of Health and Human Services will provide each state with a planning grant to assist the state in developing and implementing health care reform.

Each state is then expected to participate in the system, and to pass implementing legislation consistent with the Health Security Act. Our expectation is that all states will decide to participate.

In developing legislation, states may choose to implement a single payer system or a system structured around regional health alliances and competing health plans.

If a state chooses to implement regional health alliances, its plan for reform must specify the basic structure of its system, including:

- * The geographic boundaries of its regional health alliances.
- * The governance structure of its regional health alliances.
- * Specification of health plan certification standards.

States implementing single payer systems must also specify the structure of their systems, and still must ensure universal coverage for the nationally-guaranteed, comprehensive benefits package.

Upon enactment of a state's implementing legislation, HHS provides the state with an implementation grant to assist the state in the start-up of the system, including the formation and initial operation of regional health alliances. The state is required to contribute a matching amount towards start-up.

If a state does not choose to participate -- a situation we do not expect to occur -- HHS will instead establish regional health alliances in the state, and place a surcharge on premiums in the state to cover the cost to the federal government of establishing and overseeing the system.

The Health Security Act establishes a window within which states will implement reform. States may begin implementation as early as January 1, 1996, or as late as January 1, 1998. Once a state implements reform, the provisions of the Health Security Act take effect, including:

- * Employer and family premium payments.
- * Federal financing of discounts for employers, low-income families, and early retirees.
- * Enforcement of premium caps.

A number of states have been quite active in the area of health care reform, and we expect those states to be among the first to implement the Health Security Act. It is critical that the federal government provide these states with the tools to implement reform as they are ready. Other states will require additional time, which is why we have provided for a two-year window for implementation.

Other elements of the Health Security Act are phased in on a similar timeframe. Coverage of prescription drugs under the Medicare program, for example, begins January 1, 1996. The new home and community-based long term care program is phased in gradually over the period 1996 to 2000.

We have had extensive discussions with state and local officials, and are persuaded that the proposed phase-in schedule allows those states that want to move quickly to do so, while still permitting sufficient time to guarantee that all Americans will be guaranteed high quality, affordable coverage by 1998.

Transition Insurance Reforms

It is our view that we can most effectively provide health security that is affordable to employers and families by implementing comprehensive reform as quickly as is practicable and responsible. It is only through comprehensive reform that we can truly guarantee universal coverage and cost containment.

The current insurance system -- with exclusions for those with pre-existing conditions, higher premiums for those who are older or sicker, excessive administrative costs, and unrestrained premiums for everyone -- must be reformed. And under the Health Security Act, the rules change dramatically. Health plans must enroll anyone who wishes to do so, regardless of age or health status, and charge a community rate through a health alliance area. Administrative costs are reduced, and premiums paid by employers and families are capped.

However, during the transition to comprehensive reform in a state, it is critical that we protect existing insurance coverage for employers and families. We must ensure that insurers do not drop the most vulnerable in anticipation of a system in which they are forced to compete based on price and quality, rather than their ability to attract the healthy and avoid the sick.

The Health Security Act therefore includes a series of transitional insurance reforms that guard against the most egregious abuses by health insurers prior to the creation of a fully reformed market and the formation of health alliances. These reforms, enforced by the Department of Health and Human services, include:

- * Health insurers are prohibited from terminating or failing to renew coverage for a group or individual, except in cases of non-payment of premiums, fraud, or misrepresentation in an application for coverage or claim for benefits.
- * Insurers are required to provide coverage for new employees of an employer that purchases insurance, regardless of health status.
- * Exclusions for pre-existing conditions are limited, and individuals who are continuously insured are not required to meet a new waiting period for pre-existing conditions when switching coverage.
- * Self-insured health plans may not arbitrarily reduce benefits for high cost illnesses (e.g. AIDS).
- * The National Transitional Health Insurance Risk Pool is established to provide coverage to individuals who are unable to obtain private coverage because of their health status.

- * The Secretary will determine a threshold rate of increase for premiums, , based on increases in health care costs and utilization, previous trends in health insurance premiums, and conditions in the health insurance market. Insurers will be required to obtain prior approval for premium increases higher than the threshold percentage set by the Secretary.
- * Premium increases cannot be varied according to the health status of the group or individual.

These transitional insurance reforms by no means represent comprehensive reform, as ultimately envisioned by the Health Security Act. They will, however, protect against the most extreme abuses we see in the insurance market today, and they will ensure an orderly transition to a system that guarantees health security for all Americans and effective control of health costs.

WORKERS COMPENSATION AND AUTOMOBILE INSURANCE HEALTH BENEFITS UNDER REFORM

The Health Security Act proposes fundamental reforms to the health insurance system that will improve quality while reducing the expected growth rate of health care costs. Title X of the Act provides for the coordination of the health benefits provided under workers compensation and automobile insurance with the financing and delivery of health care under a reformed health insurance system. By coordinating the delivery of services in these systems, the Act will improve the efficiency and quality of care provided to the injured workers and injury victims.

Title X of the Health Security Act sets a framework for the integration of workers compensation and automobile insurance health benefits into the reformed health care system. As a first step, the Act integrates the delivery of health care services. Injured workers covered by workers compensation and injury victims covered by automobile insurance would receive the health care services they need from the health plan they enrolled in under health care reform. Existing payers -- workers compensation carriers (including self-insured employers) and automobile insurers -- would remain financially responsible for the costs of that care.

As a second step, the Act creates a commission to study the feasibility of integrating the financing of workers compensation and automobile insurance health benefits into the reformed health care system. Financial integration could improve efficiency by eliminating the need for benefit coordination across the systems and by providing incentives to health plans to deliver medical services more efficiently.

Coordinating the Delivery of Services

The Act requires each State to amend its workers compensation and automobile insurance systems as a condition of certification by the National Health Board.

Under the Act, injured workers and injury victims generally would receive medical services (except in emergencies) from the health plan they are enrolled in for their normal health care. To be certified, health plans that use participating providers would need to include specialists in occupational medicine and rehabilitative services as part of their provider networks. Health plans would be reimbursed for providing services to injured workers and injury victims by the payers responsible for payment today -- workers compensation carriers and automobile insurers. The level of reimbursement would be based on the fee-for-service fee schedule established by each regional alliance under the Act.

An important aspect of the workers compensation system is getting injured workers back to work as soon as medically appropriate. To ensure proper coordination of medical treatment and appropriate return to work, the Act requires that each health plan have a workers compensation case manager. The case manager is responsible for working with employers and workers compensation carriers to develop appropriate medical treatment and rehabilitation plans that will provide for return to work as soon as is medically appropriate. The case manager also will ensure that the health plan complies with the legal requirements under workers compensation.

Because workers compensation and automobile insurance health benefits will be delivered through State certified health plans, the quality of care and the administrative efficiency of providing care can be improved. Delivery system integration under the Act means that medical services provided to injured workers and injury victims will be part of the Quality Management System, permitting States to apply the same quality standards and oversight to these services as they apply to other medical services delivered by health plans and health care providers. Delivery system integration also means that administrative simplification -- uniform claims forms, etc.-- can be applied to workers compensation and automobile insurance health benefits, improving efficiency and reducing administrative costs.

The Act also provides for the Department of Health and Human Services (HHS) and the Department of Labor (DOL) to develop protocols and demonstration projects that should improve quality and lower the costs of treating injured workers. The Departments are charged with working with providers and other interested parties to establish treatment protocols for common workplace injuries and illnesses. These protocols should assist providers in improving the effectiveness of medical care. The Departments are also authorized to fund demonstration projects that experiment with capitating health plans and providers for the costs of workplace injuries and illnesses. Capitation could lower costs by encouraging providers and health plans to provide services more efficiently.

The Act has a number of advantages for employers and workers:

- o Workers will be able to go to the same health plans for all of their medical services.
- o Workers compensation costs will be reduced in the short run:
 - The growth in fees for medical services will be constrained because payments for workers compensation services will be based on Alliance fee schedules;
 - Fraud and excessive utilization will be reduced because services will be provided through certified health plans;
 - Experiments with capitation payments for workers compensation medical costs could reduce current costs and pave the way for full capitation payments for work-related medical costs.
- o Costs will be further reduced in the long-run if the financing of the two systems is integrated:
 - Health plans will be fully at-risk for providing medical benefits to injured workers, which brings work-related injuries and illnesses under cost containment incentives provided in the new system.
- o Medical services provided to injured workers will be subject to the same standards and oversight for quality of care as other medical services delivered by health plans.

CONCLUSION

The President's Health Security Act establishes workable frameworks for interim insurance reforms and for integration of workers compensation and automobile insurance health benefits into the reformed health care system. Our goal for the transition is to ensure that existing coverage remains in place and affordable during the transition period between passage of the Act and the full implementation of universal coverage. Our goals for the workers compensation and automobile insurance health benefits are to improve the efficiency and quality of the delivery of health benefits in those systems. We look forward to working with members of this Subcommittee and other interested parties in achieving those goals.

Based on extensive consultation with those in the private and public sectors, however, we believe the timeframe is reasonable and achievable. And given the cost of doing nothing -- greater numbers of Americans without the security of health coverage, ever-increasing health insurance premiums for employers and families, and increasing fiscal burdens at all levels of government -- we have a responsibility to move as rapidly as possible towards a reformed health care system.

Thank you again, Madame Chairman and members of the Subcommittee for the opportunity to testify before you today regarding the provisions in the President's Health Security Act related to the period of transition to a reformed system and coordination with workers compensation and automobile insurance. I would be happy to answer any questions that you may have.

**Questions by Reps. Stearns and Greenwood
to Gary Claxton, HHS**

1. Under the transition rule, certain rating rules do not apply if the underlying rates are subject to rate approval. However, the definition of "rate appraisal" has been a long-standing point of dissention between insurers and many insurance departments. How do you interpret "rate approval" as it applies to the transition section of the Clinton plan?

Response:

Section 11004(c)(2)(E) contains an exception for premium rates that are both subject to the "prior approval" of a state insurance commissioner and which are actually approved by such commissioner. This exception is intended to apply only to those situations in which an insurer is prohibited by law from increasing the premium for a policy or contract unless the increase has been previously approved by the state insurance commissioner or similar official.

2. Please define insurance as used by H.R. 3600, the Health Security Act?

Response:

The term "insurance" generally refers to a process or business in which a party (e.g., the insurer) indemnifies or guarantees another party (e.g., the policyholder) against loss resulting from a specified contingency or peril. (See Webster's New Collegiate Dictionary).

3. Please define financial solvency as used by H.R. 3600, the Health Security Act?

Response:

The term "financial solvency" refers to an insurer's financial capacity to meet its obligations to pay claims for health benefits.

4. Is a Health Maintenance Organization (HMO) an insurance company or a provider?
 - b. How does an insurance company handle risk and transfer risk?
 - c. How does an HMO handle risk and transfer risk?
 - d. Should the same standards apply to anyone accepting a transfer of risk in the health care system?

Response:

In general under the Health Security Act, Health Maintenance Organizations (HMOs) are treated similar to insurers if the context relates to accepting the financial responsibility to provide health benefits to eligible individuals.

- b. In general, insurers "handle" risk by agreeing to pay or reimburse the cost of covered health care services incurred by their policyholders in exchange for a fixed premium. Insurers can "transfer" some of the risk they have assumed through the purchase of commercial reinsurance or through contracts or other arrangements with health care providers (although the transfer generally does not diminish the insurer's ultimate obligation vis-a-vis the policyholder).
- c. HMOs handle and transfer risk in a manner similar to insurers. HMOs, by definition, have contracts or other arrangements with health care providers (including in many instances owning health care facilities).
- d. The same factors should be considered in developing standards for the different types of entities that accept health care risk in the health care system. For example, in determining minimum capital requirements for health plans, relevant factors might include the number of enrollees in a health plan, the size of its service area, the number and type of competitors, and the method of paying providers (including any provisions for sharing risk). These factors could result in different requirements for different types of health plan arrangements.

5. How is the term reinsurance used and what does it mean in the context of the Health Security Act?

- a. Section 1541(b)(1) states: "IN GENERAL. The methodology developed under this section may include a system of mandatory reinsurance, but may not include a system of voluntary reinsurance." What does that statement mean?

Response:

In the Health Security Act, the term "reinsurance" generally refers to public programs set up by states through which insurers share part of the costs of treating specified high cost conditions. The concept is similar to the reinsurance programs established by states as part of community rating and small-group insurance reform.

- a. The statement in 1541(b)(1) is intended to mean that all health plans offering coverage in a regional alliance area must participate in the reinsurance arrangement established by the state. The term "voluntary reinsurance" refers to a reinsurance system in which an insurer would have an option not to participate.

Section 1203(g) states: IMPLEMENTATION OF MANDATORY REINSURANCE SYSTEM. If the risk adjustment and reinsurance methodology developed under section 1541 includes a mandatory reinsurance system, each participating State shall establish a reinsurance program consistent with such methodology and any additional standards established by the Board. What does that statement mean, and, in particular, what does the term establish mean?

- If States act as reinsurers, what methodology will States use to cover risk?
- If States act as reinsurers, how will states fund coverage of risk? Is there a capital base that underlies reinsurance system established by State?
- What participants in the health care system will use reinsurance facilities? How will reinsurance apply to each participant? What will the impact of on HMO capitation systems?
- How do financial solvency requirements pertaining to reinsurance relate to such requirements on other participants in the health care system?
- Does Health Security Act envision a role for market-based reinsurance firms?

Response:

The statement means that a state, as a condition of becoming a participating state under the terms set forth in the Health Security Act, must establish a reinsurance program. The intent is that the reinsurance program would be similar in structure to those set up by states as part of their community rating and small group insurance reform efforts.

Mandatory reinsurance is a way for all insurers to share part of the costs of certain high risk and high cost diagnoses and cases. The methodology for how the reinsurance programs will operate will be promulgated by the National Health Board.

It is not contemplated that states will act as reinsurers under the risk adjustment and reinsurance methodology. As discussed above, reinsurance in this context refers to method

for insurers to share the costs of certain higher cost cases. The system is intended to operate on a zero-sum basis -- the risk of these cases is shared by all insurers but there is no transfer of risk to states. All risk is covered within the amount of premiums owed to insurers; there is no separate capital base for reinsurance (because there is a sharing of risk within the system; not a transfer of risk outside of the system).

The risk adjustment and reinsurance methodology apply to insurers (including HMOs). The impact of the system on these entities is that part of the costs of treating enrollees with specified high cost diagnoses will be shared by all insurers regardless of which insurer those enrollees choose.

Because state established reinsurance systems are a method of sharing risk among all insurers, financial solvency requirements do not apply.

It is assumed that insurers may still wish to use commercial reinsurance to increase the predictability of the health care risk.

7. How is the term guaranty fund used and what is its role in the context of the Health Security Act, and what are its source of funds?

Response:

The term "guaranty fund" includes both entities established by states to assume the obligations of insolvent insurers and the entity established by the Department of Labor for paying the guaranteed benefits under corporate alliance self-insured health plans. In Health Security Act, the context refers to a requirement that states establish such entities (or amend the responsibilities of existing guaranty funds) to assume the obligations of insurers that become insolvent for payments to health care providers for the benefits covered in the comprehensive benefit package. In the case of corporate alliance health plans, the obligation assumed includes the benefits covered in the comprehensive benefits benefit package and supplemental benefits. The sources of funds are, in the case of guaranty funds for state-certified health plans, an assessment (not to exceed 2%) on premiums of other insurers offering certified health plans, and, in the case of self-funded corporate alliance health plans, assessments (not to exceed 2%) on other self-funded corporate alliance health plans.

8. How are fiduciary interests defined in the context of the Health Security Act?

- a. What fiduciary role is performed by the alliance and state and Federal governments, and what are the fiduciary relationships of each to the health care system?
 - b. What fiduciary role does the reinsurer play in the health care system?
 - c. Who or what is the buyer in the health care system?
- Response:

A fiduciary relation is one that relates to or involves a confidence or trust (See Webster's New Collegiate Dictionary). Under the Health Security Act, the term has a meaning that is similar to the meaning it has under the Employee Retirement Income Security Act (ERISA) (29 U.S.C. 1001 et. seq.)

- a. In general, Federal law and State law establishes the duties and responsibilities of public employees that handle public funds. Under the Health Security Act, regional alliances are required to safeguard family, employer, and public payments in accordance with fiduciary and other standards established by the Secretary of Health and Human Services in consultation with the Secretaries of Treasury and Labor. Those standards will be set forth in regulation. (See section 1361). Further, corporate alliances sponsors are subject to the specific fiduciary provisions of ERISA. (29 U.S.C. 1001 et. seq.)
- b. There appears to be no special fiduciary role played by reinsurers. To the extent that state-established reinsurance funds have discretion over assets or funds held for others (e.g., insurers), they may be in a fiduciary relationship with respect to such persons.
- c. Under the Health Security Act, families choose the health plan into which they will enroll, and so could be considered the buyer of health care. Employers and families are required to make contributions (as set forth in the Act).

President Clinton has stated that his health reform package will provide security to the American people. What is meant by the word security?

Response:

The idea of security under the Health Security Act is that the all Americans would be entitled to comprehensive health care benefits that could never be taken away. In addition, the Act provides for discounts and limits on premium growth to assure that health care remain affordable for all.

10. The Health Security Act uses the term risk in a variety of contexts. What is meant by the term risk?
- In section 1541, you discuss risk adjustment, risk categories, and risk factors. What do each of these terms mean?
 - In section 1551, you discuss risk sharing and risk history. What do each of these terms mean?
 - In section 1127, you discuss behavioral risk factors. What does this term mean, and what elements comprise the factors?
 - In section 1114, you discuss risk assessment and high risk populations. What do each of these terms mean?
 - In section 1222, you discuss financial risk. What does this term mean?
 - In section 1329, you discuss bearing risk and insurance risk. What do these terms mean?
 - In section 5311, you discuss risk management. What does this term mean?
 - In section 6124, you discuss excess risk percentage, extra risk proportion, and average demographic risk. What do these terms mean?
 - In section 4132, you discuss risk sharing contracts for HMOs. What does this term mean, and how is risk shared in the HMO context?
 - In section 1222, you discuss capitated, at-risk basis. What does this term mean, and to whom or to what does it apply?
 - In section 11007, you discuss a national transitional health insurance pool. What does this term mean and how does the pool operate?

Response:

The term risk generally means the possibility of loss or injury. (See Webster's New Collegiate Dictionary). Under the Health Security Act, the context generally refers to the risk of financial loss associated with the cost and utilization of health care services.

- The term "risk adjustment" generally means a system that adjusts payments to insurers to reflect the demographic

and/or health status characteristics of its enrollees, as measured against a reference (e.g., normal distribution of such characteristics in the community).

The term "risk categories" refers to the categories defined by the factors specified in Section 1541(b)(2). For example, if age is defined as a risk factor, then a category would be a defined age range, such as people between 35 and 40 years of age.

The term "risk factors" refers to the factors specified in Section 1541(b)(2).

- b. The term "risk sharing" refers to the arrangements that health plans have with participating providers to share the risk related to health care costs and utilization. The term "risk history" appears to refer to the previous experience of the health plan in assuming risk.
- c. The term "behavioral risk factors" refers to behaviors and activities of people that may adversely affect their health. Examples are smoking and excessive alcohol consumption.
- d. The term "risk assessment" refers to an evaluation of a person's health care risks, including any behavioral or other factors that can adversely affect the person's health. The term "high risk populations" refers to people who have a higher than average risk of using health care services.
- e. The term "financial risk" refers to the potential costs associated with a person's (or a group's) use of health care services.
- f. The term "bearing risk" refers to taking the responsibility for the potential costs associated with a specified contingency. The term "insurance risk" refers to the potential financial costs associated with insuring a population for particular contingency. The section prohibits regional alliances from directly assuming the financial responsibility associated with providing health care. Regional alliances contract with health plans to assume insurance risk.
- g. The term "risk management" generally refers to taking steps to manage or control the potential losses associated with a risk. An example would be instituting a workplace safety program to control or reduce an employer's risk related to workers compensation.

- h. We were unable to find the terms "excess risk percentage" or "extra risk proportion" in section 6124. The term "excess risk proportion" is defined in the bill as follows:

"The 'excess risk proportion', specified in this paragraph, with respect to an employer and an alliance area, is a percentage that reflects, for the year before the first year in which this section applies to the employer, the amount by which

(i) the average demographic risk for employees (and family members) described in paragraph (2)(B) residing in the alliance area, exceeds

(ii) the average demographic risk for all regional alliance eligible individuals residing in the area.
"

The term "average demographic risk" refers to the cost of providing the comprehensive benefit package to the average person (e.g., average age) in the area.

- i. The term "risk sharing contracts" refers to contracts entered into with health maintenance organizations and competitive medical plans under section 1876(a)(1)(C) of the Social Security Act.
- j. The term "capitated, at-risk basis" refers to contracts and arrangements similar to those referred to in section 1876(a)(1)(C) of the Social Security Act.
- k. The term, "national transitional health insurance pool" refers to a program that the Secretary of Health and Human Services is authorized to create to provide coverage to uninsurable people during the transition period between passage of the bill and implementation of universal coverage in a State. The pool would operate under rules promulgated by the Secretary. The pool is intended to operate similar to the high risk pools currently operating in about 28 States.
11. What numbers or studies has the Administration used in its assumption that merging workers compensation and automobile medical into the Clinton health plan will ultimately decrease costs? Please supply the Subcommittee with those financial assumptions.

Response:

We are aware of no reliable, comprehensive studies that evaluate the potential savings that could be achieved by

merging workers compensation and automobile medical insurance into the health insurance system. The evaluation that merging the system could produce savings is based primarily on the comparison of the inefficiency and high costs (both service and administrative) associated with the current workers compensation system with the efficiency and savings that could be achieved by delivering workers compensation health benefits through competing health plans in a highly competitive health care system.

12. Has the Administration considered the variation in state auto indemnity laws and the different impact the proposal will have? (Some states have no fault laws with different tort thresholds; some allow a choice between no fault and traditional tort, even the traditional tort states have a wide variation in the first party medical benefits provisions?)

Response:

These variations have been considered. The Health Security Act initially does not change the financial responsibility for health benefits covered by automobile insurance; it provides that the covered health services would be provided through the injured person's health plan. The impact of these variations on financing would need to be considered by the Commission on Integration of Health Benefits that would be created under Title X of the Act.

13. Does Title X contemplate that the health plans receive payments both from auto insurers provide coverage directly to injured persons and from auto insurers providing liability coverage for auto accident related medical expenses? Shouldn't this be clarified in the bill?

Response:

Under Title X, health plans receive payment for providing services to persons injured in automobile accidents from the responsible automobile insurer, whether the liability is first party or third party.

14. Community rating is established in the Administration package. This means that all employers in a geographical area pay the same premium for workers compensation medical costs, regardless of their health and safety records. This also means that safe employers are subsidizing unsafe ones, since the costs of workplace health care would be borne by all employers. Does the Administration intend to give a competitive edge to unsafe employers. If not, how would you propose to avoid such subsidization?

Response:

The Health Security Act does not establish community rating for workers compensation health care benefits. The Health Security Act does not change the financial responsibility for health benefits covered by workers compensation; it provides that injured workers would receive services through their health plan, but that existing workers compensation insurers would remain financially responsible for the costs of services.

The Commission on Integration of Health Benefits, as part of its report to the President, would consider how workers compensation health benefits would be financed (e.g., whether through experience or community rating) if workers compensation health benefits are fully merged into the health care system at a later date.

15. Merger would require at least \$24 billion in new health care financing. All of the medical costs that are currently financed through workers compensation insurance, self-insurance, and monopolistic state funds would have to be paid for by the national plan.
 - a. Although Administration officials claim that overall health care reform can be paid for in "administrative saving" and in single-digit employer "contributions," some detractors say that this will not be sufficient to pay for everything outlined in the Health Security Act. How would you propose to finance the additional \$24 billion that is currently part of the insurance premium?
 - b. Currently, medical coverage for workplace injuries is "first dollar," i.e., injured workers pay no co-pay and no deductibles. Since the Administration package would virtually eliminate first-dollar coverage, how do you plan to convince American workers that they should begin to pay part of the costs of their injuries on the job.

Response:

- a. The Health Security Act does not change the financial responsibility for health benefits covered by workers compensation; it provides that injured workers would receive services through their health plan, but that existing workers compensation insurers would remain financially responsible for the costs of services.

The Commission on Integration of Health Benefits, as part of its report to the President, would consider how workers compensation health benefits would be financed if

workers compensation health benefits are fully merged into the health care system at a later date.

- b. The Health Security Act does not change the benefits or services provided to injured workers under state workers compensation systems. Section 10002 (c) specifically states that:

"Nothing in this part shall be construed as requiring an injured worker to make any payment (including payment of any cost sharing or any amount in excess of the applicable fee schedule) to any health plan or health care provider for the receipt of workers compensation services.

Workers compensation is responsible for "wage loss" as well as medical benefits. A merger as contemplated in Title X would uncouple today's system of a workers compensation product in which there is a hands-on, aggressive medical management of the injury plus payment of wages lost while the worker is recuperating.

- a. It seems to be good policy to leave these two elements -- disability management and payment of loss wages -- coupled in the workers compensation product. Where a worker's medical is aggressively managed, the worker will be able to get back to work sooner, even if in a "light" duty assignment. That kind of aggressive management promotes greater productivity in America's workplaces. Why would the administration institute Federal Government program to manage the care of injured workers when it is already being done in the private sector?

Response:

The Health Security Act does not create a Federal Government program for workers compensation. Health benefits would continue to be provided through private-sector insurance.

A merged system would result in another costly Federal bureaucracy, and the real loser here could be the injured worker. It is unlikely that Federal bureaucrats would have the same focus in the worker as does the workers compensation insurer, who also has a financial interest in seeing that the worker return to work as quickly as medically appropriate. Do you really believe that over-worked health bureaucrats will be more receptive to the needs of injured workers than workers compensation insurers, given that insurers have a financial interest?

- a. If the new health bureaucracy adds the special expertise that it will need to deal with workplace injuries, won't there be duplication, since the insurance industry already has such expertise in place? This seem to add even more new costs to this new system.
- b. Does this mean that the Administration would put one segment of the workers compensation insurance industry out of work so that similar jobs can be created in the Federal Government?

Response:

The Act initially leaves financial responsibility for workers compensation health benefits with workers compensation insurers, who will remain financially interested in working with health plans to manage the care given to injured workers. If workers compensation health benefits are fully merged into the health care system, there are several ways that compensation to health plans could be structured to reward plans for promoting rapid return to work. The Commission on Health Benefit Integration would need to consider this issue as part of its consideration of integration of the two systems.

The Health Security Act does not create a Federal Government program for workers compensation. Health benefits would continue to be provided through private-sector insurance.

Under the Health Security Act, workers, and not employers, choose their health plan. It is likely that health plans would be even more responsive to the needs of injured workers than current workers compensation insurers.

- 18. The rehabilitation of serious workplace injuries requires constant focus on the injured worker-medical treatments, rehabilitation and working with the employer to find appropriate "light duty" assignments until the worker is able to return to his job.
 - Do you actually think that the health plans will intervene effectively with employers in this new bureaucracy?
 - Can you name a government program that you would like to model this after?

Response:

We believe that the provisions of Title X will actually improve coordination of medical services provided to injured workers in many cases. Section 10001(c) of the Act requires that each health plan have a case manager to ensure that the plan of treatment for an injured worker is coordinated with the workers compensation insurer and the employer.

Again, Title X does not create a Federal Government program for workers compensation. Health benefits would continue to be provided through private-sector insurance.

Mrs. COLLINS. Thank you, Mr. Claxton. Let me make a statement that I should have made at the beginning of the hearing, and that is that we operate under the 5-minute rules in the House of Representatives, and it was just pointed out to me by counsel that I forgot to mention that. And so when our witnesses appear before us and hear that 5-minute gong, it means that your time for summarizing your statement will have expired. However, we want you to know that your full and entire statement will be made a part of the record.

I have just made sort of an arbitrary decision, because we have so many questions to ask, and this is the only hearing that we are going to have on this particular issue. We are going to be more lenient in the amount of time that we allow ourselves, if you will, to ask questions. So we are going to ask questions in 10-minute periods of time. I will take 10 minutes first. Thank you.

Mr. Claxton, the issue of who gets to choose the health care provider in a worker compensation case is a major concern for both the employers and the workers. And, apparently, the employers and insurers are concerned that workers will stay away from work longer than necessary, while workers are concerned that they will not get as much health care treatment that they need and will be sent back to work earlier than is appropriate.

How does the Health Security Act resolve this particular problem?

Mr. CLAXTON. This is the number one issue in thinking about how you would coordinate the two systems. And something we spent a great good deal of time thinking about. In general, what we have done is—well, let me—a little bit of background.

About half the States, it is not quite half, it is roughly half the States, let the employee choose where they go, choose the provider and about half the States let the employer choose the provider. What we tried to do in the Health Security Act was split it down the middle and to say that employees should go to the health plans they use for other services. So you wouldn't wait until you were injured on the job to have chosen your place of delivery.

By and large, you would have done it because it would be part of the health plan you chose for health care reform. That has not satisfied a number of the employers. They feel like they need more control over the situation. It is not surprising that organized labor feels just the opposite. This is part of a continuing battle on workers' compensation. I think it is a shame that we can't learn from some of the States where there has been a more cooperative approach and where employee choice isn't nearly as important as creating a system where there is less litigation.

What we tried to do here was work through a more cooperative approach. I am not sure that we—I am sure we have not made everybody happy in that regard. If I could make one other point on that is interesting.

Mrs. COLLINS. Please.

Mr. CLAXTON. When we looked at this, and obviously since the States are split about half and half, there is something of a laboratory, there is no—there is no evidence that costs are any lower in States where employers have control of where the worker goes than where employees have that ultimate control. So to some extent this

might be much ado about nothing, although there is very deeply held beliefs about it.

Mrs. COLLINS. It is my understanding that the Clinton Task Force predicts that businesses are going to pay lower worker compensation premiums if worker compensation is merged with the health care system than they do now. Could you explain why that might be the case?

Mr. CLAXTON. There are a couple things about these provisions which we think will lower the cost. The first is, is trying to stop price discrimination against the workers' compensation system by having the payments for workers' compensation and automobile health benefits made on the same fee for—and the same fee schedule that alliances use for fee-for-service medicine.

If you look at the constraints on growth that will occur both through competition on the health insurance side and if that isn't effective, by the premium caps, you are looking at rates of growth that are much lower than we are seeing today. If you look over the last 10 or 12 years or so, health care—the only thing that is going up faster than health insurance are the health benefit portion of workers' comp.

This isn't a system that is working particularly well or has found a—has found a set of coherent reforms. When we talked with lots of people, no one told us that they thought the workers' compensation worked particularly well, except workers' compensation insurers, which wasn't really surprising. So that would help limit the rate of growth.

In addition, we have—the bill has the Department of Health and Human Services and the Department of Labor working together with the medical community and payers and others to develop some protocols for the work—excuse me. For the work related—the most common work-related injuries and illnesses treated in workers' compensation. Those protocols, we believe, have to look at both the appropriate treatment of those illnesses and injuries, but also the appropriate time of getting back to work.

By doing that, we can start to look at holding health care providers accountable for getting people back to work, because we will have some standards by which to look at them. In addition, we want to look pretty closely at how the quality management system that we have under health care is going to work on workers' compensation.

For the first time we will be able to look at the health care providers and the health plans and see if they are doing a good job on quality. A lot of the problems in workers' compensation health care costs have to do with bad quality and people who aren't really doing a good job in terms of appropriate treatment and our quality management system will help us identify those people.

Mr. CLAXTON. And, finally, I think by having people go to their health plans, especially those people who are in network health plans, health plans don't want to have bad utilizers as part of their—as part of their networks. And while they are—and while they are not at risk at least initially for workers' compensation benefits, they are at risk for other benefits and they don't want those bad utilizers as part of their networks.

Mrs. COLLINS. Well, do you think that total health care costs would increase if work-related injuries were shifted into the health care system since there would be no incentive for businesses to keep the workplace safe?

Mr. CLAXTON. We did not as the first step in health care reform call for the financial integration. So the continuing types of experience rating that exists now would continue under title X.

One of the things the commission will have to look at is whether if there is a financial integration, it is appropriate to move away from experience rating. It would be possible to maintain experience rating, but to integrate them otherwise in terms of capitating the health plans financially.

Mrs. COLLINS. Well, what do you think about the premiums? Do you think that premiums can act as an incentive or a deterrent for certain types of behavior? You talked about behavior. For example, if drivers know that their automobile insurance premiums were going to double if they get into an accident, wouldn't you think that they would have more of an incentive to drive more carefully?

Mr. CLAXTON. Yes. Again, while there is—I think it is pretty clear that both experience rating on the workers' comp side and the kinds of surcharges on the automobile side, can promote safety. And there is nothing about this act that suggests that we are going to change the way those rates are made now.

Mrs. COLLINS. Well, do you think that merging automobile insurance, for example, into an alliance health care system, might reduce this incentive effect?

Mr. CLAXTON. Only if we—only if we change the way the financing is put together. Again, in title X, people go to their health plan but the automobile insurer remains financially liable and can again, use the same type of rating it uses today to charge the driver. If we do a financial integration, one of the things the commission will have to consider is whether or not they want to—whether or not they want to recommend that we change the way the premiums are made.

Mrs. COLLINS. Well, what about merging worker compensation insurance into an alliance health care system, would that reduce the incentive employers would have to keeping the workplace safe?

Mr. CLAXTON. Again, I don't think so in the first step, because we are not changing the experience rating for workers' compensation. If there is a financial integration the commission will have to consider that issue.

Mrs. COLLINS. Let me ask you about the transition rules in title XI. Do you think that those will make it easier for individuals to purchase health insurance? If you do, tell us why. If you don't, tell us why.

Mr. CLAXTON. I am very worried about the short transition period we have to health care reform. It is not—it has nothing to do with alliances, and it doesn't necessarily have anything to do with universal coverage. It has us moving from a system where the rates are very disaggregated, and especially across the markets, to systems under almost any of the bills where a large part of the population is in a community rate and has some sort of guaranteed access to coverage.

In that case, the insurers who previously have survived on risk selection or even those who have done it as a defense mechanism, I don't want to talk about any blame here, are going to have to think about what is their competitive position 2 years from now when reform happens.

We have seen some experience in the States even with the modest reforms in some of those States where groups got dropped because the insurer didn't want them as part of their future community rate. That is a much more potential—that is a much bigger potential problem here. So that leads you to think about two potential problems.

One is that groups will get dropped, and second, that the sort of market for people getting insurance because it is a short-term market now, you know, the rules are going to change in 2 years, there may not be a very lively market for new business.

What we have done in the reforms are to address that in a couple of ways. One is to make sure that groups can't get dropped, and then as a sort of an ultimate backup, was to create an insurance risk pool for people who really can't find coverage in the market because of their health status.

Mrs. COLLINS. Well, some States already have a health insurance risk pool in operation. Will the provision of title XI allow them to stay in operation?

Mr. CLAXTON. It calls for the Secretary to coordinate with those pools, and they can work out whatever agreements they think are appropriate.

Mrs. COLLINS. You, I take it, believe that coordinating workers' compensation health benefits with the new health care system is going to increase the quality of care that is provided to the workers; is that not the case?

Mr. CLAXTON. That is the one thing I am fairly sure of, the coordination. The rest of it is——

Mrs. COLLINS. Why are you sure that it will increase the quality of care?

Mr. CLAXTON. I believe that our quality management system where we are going to start to collect information about, at the encounter level, about what the—what people essentially—what is wrong with people, what treatments were given to them, will let us look at both how health plans organize their care and how individual providers do and allow us to compare them with other providers.

It lets us start to get at the outcomes that we need to do a good job in assessing quality. In addition, the protocols which the Federal departments will work on with everyone else in the marketplace, will start to give us some standards so that we can look at how well the current system is operating compared to how well it should operate.

Mrs. COLLINS. Thank you.

Mr. Stearns.

Mr. STEARNS. Thank you, Madam Chairwoman. You know, as we discuss here, you use the term, "coordinate" or "merger," and you use these terms interchangeably.

Mr. CLAXTON. I am trying not to, so I am sorry if I was.

Mr. STEARNS. I think we will have to somewhere down the line maybe get from the administration you know, a clear understanding or at least understanding from this hearing.

Let me just ask you a little bit about the \$24 billion that has been touted for this new health care financing to cover this portion. As we understand it, merger would require at least \$24 billion in new health care financing. All of the medical care—medical costs that are currently financed through workman's compensation insurance, self-insurance and monolithic State funds, would have to be paid for by the national health plan.

The question is, although administration officials claim that overall health care reform can be paid for in "administrative savings", and in single digit employer "contributions", some people say that this will not be sufficient to pay for everybody outlined in the Health Security Act. How then would you propose to finance the additional \$24 billion that is currently part of the insurance premium?

Mr. CLAXTON. Sure. In the—again, you are talking about a second potential step of a full integration. In the first step, we don't change the financing at all. One of the reasons we created the study commission is that the questions of how you would charge premiums, continue to charge premiums to employers for workers' compensation and premiums to drivers for automobile insurance, is an important question in a merged system.

You have to think about whether you would want to expand it and community—expand the existing type of community rate to employers and whether or not that would have employees make some sort of copayment, or whether you would just charge a separate additional premium that is similar to current workers' compensation premiums and charge it directly to employers. Those types of—and there is a number of other very difficult questions.

Those types of questions are—need to be addressed, I think, at a separate level, and where we have more time to think about the implications for that system. That is why we have tried to move in the first step towards a rational coordination of the two systems, and then think as a second piece whether or not the financial merger was appropriate.

Mr. STEARNS. Mr. Claxton, then, following that thinking, how can the commission make an informed decision as to "merger", when it is impossible to evaluate the effectiveness of the health care reforms?

Mr. CLAXTON. Because the commission reports earlier than the coordination takes effect. We wanted the commission—because this was an issue that was of interest to so many people, and actually a number of Members of Congress who wanted the commission to make its report as soon as possible, it is entirely likely that commission could recommend a certain set of additional studies that need to be done once the system comes into place. It could also start to address some of the issues that are appropriate and say it is not a good idea. But it gets us a start at looking at these important issues and whether it is even something we should pursue.

Mr. STEARNS. The Clinton plan contains no provision for insurance companies to sell or terminate blocks of coverage during the transition period. Why did your legislation not permit companies to

exit a market, since forcing companies to remain in a market when it is not fiscally sound could drive those companies into insolvency?

Mr. CLAXTON. We addressed that provision by authorizing the Secretary to issue regulations on transition—on assumption reinsurance. I believe it says “may” and perhaps it should have said “shall.” The ability—there are so many ways that you can use assumption reinsurance or the transfers of blocks of business to get around both State rating laws and the types of rating laws we have put in place here, that it needs special considerations.

For example, if you look at the model State insurance reform laws, there is a very long set of sections on assumption reinsurance to try to protect against the type of abuses that could occur if you wanted to get around the rating laws by transferring part of your business and not all of your business. We assume issuing regulations that are similar to that, but we want to be able to work with the interested parties. But it has to happen quickly, and we recognize that.

Mr. STEARNS. Are these regulations going to be provided in a timely fashion?

Mr. CLAXTON. The entire act authorizes interim final regulations, and we would think that these regulations and the regulation as to the specifics of the rating provisions during the transition would have to have our top priority.

Mr. STEARNS. Requiring health plans to get prior approval for rate increases in excess of a certain amount essentially is a premium cap. Premium caps will make markets less predictable as health plans will be forced to respond to rising costs by changing the product design; that is, benefits offered. Aren't you concerned about possible market disruptions as a result?

Mr. CLAXTON. I do not, maybe because of my background as an insurance regulator, I don't think the term “prior approval” means that you arbitrarily limit premiums. I think what it means is that when a premium increase is above an amount that you think is sensible, that you at least should look and see the underlying reasons for that premium increase before you approve it.

As I said, during the transition, there are some real concerns about there being something of a hard market, about certain people being essentially trapped in their health insurer, and then you have to think about there are certain insurers who today are making their living through risk selection who probably won't see much of a future for themselves even a few years down the line in any of the bills that you have before Congress.

The smartest thing they could do during the short-term is to profiteer before they got out of the market, because they have some trapped people. They can raise rates as much as they want, and those people who are sick can't go anywhere. The prior approval in the threshold, though, is to say that below the threshold the markets should work as it should. We have equalized the rate increases, but insurers should be able to take what they need. But to protect against short-term profiteering, we at least want to look if that threshold is above a certain level. And probably we should all talk about what that level is so we can put a level of predictability in the market, as you stated.

Mr. STEARNS. Requiring health plans to apply equal increases across market segments, large groups, small groups and individuals, would place those plans that offer coverage in all three markets at a competitive disadvantage, since this does not gradually move individuals from their current experience rated premiums to community ratings. Why did you include this requirement?

Mr. CLAXTON. We included this requirement as part and parcel of the provision that says you can't drop individual groups or individuals or certain blocks of business. If you can selectively apply large rate increases to certain parts of your business, you can fairly quickly give them the idea that you don't want them around anymore. You can get rid of them.

Averaging out the rates of increase was the way we could make sure that, A, we could apply some sort of reforms during the interim period; and B, that we could protect groups from arbitrary rates of increase. I think one of the things that is important here is to—and I worked on the State, the model laws that most States have adopted for small group insurance market reform.

I think it is very appropriate in a marketplace that is operating well, or is operating on a stable basis, but during the transition period, there are a number of competitors who don't care very much about getting new business. All they are trying to do is prepare for the new system 2 years down the line.

Almost all of the State insurance reforms are just relative rate reforms. They tie the rate of increase to any particular business to what happens with the new business rate or the lowest business rate. If you are willing to raise everyone's rate up, there are no rate constraints. And, again, those only apply generally to groups under 25 or 50.

What we need to do is protect people in what is probably going to be a dysfunctional market during the transition to the extent we can.

Mr. STEARNS. There is no correlation between the cost of providing coverage to the uninsured, high risk population through the national high risk pool and the premiums charged by the Secretary of HHS. There are no incentives for keeping costs equivalent to premiums charged. Also there are no requirements of actuarial soundness.

Why are such safeguards not included? What is to keep the cost of the national risk pool from getting completely out of control, especially when those costs are borne by insurers and not the Federal Government, which is running the risk pool?

Mr. CLAXTON. Right. We funded the risk pool much the same way States do. We started out with a premium that is about 1½ times the standard premium. Under State experience, that will pay for about half the losses. We expect to get the other half of the losses through the assessments on self-funded employers and on insurers. There is a limit on the assessments we can charge to those people and also a limit on the borrowing authority that the Secretary has to fund the risk pool.

What the Secretary has to do is look at the amount of money that she can get through assessments, and the premium, which has to be at least 150 percent, and charge a premium that balances that equation. That is really the way State risk pools work now.

The premiums are not actuarial. What they are, is a roving percent above the standard premium that balances the amount you can get from assessments with the amount you can get from premiums. And that is the way we funded this.

Mr. STEARNS. The Secretaries of HHS and Labor would have dual regulation of health plans during the transition period. Wouldn't this result in uneven regulation and different standards for health plan sponsors?

Mr. CLAXTON. We have a bifurcated market now in the sense that those plans that are self-funded are primarily covered under ERISA and those plans that are insured are primarily covered by the States. What we have tried to do is look into the future at what the Secretary of Health and Human Services is going to have to do under the new system in terms of health reform and the insured market would stay with the Department of Health and Human Services and the Department of Labor can focus mostly on the self-funded market.

They are under two different regulatory systems and we thought that was appropriate.

Mr. STEARNS. Transition rules apply until a State implements coverage under the Clinton plan. States will be implementing coverage over a multiyear phase-in period. As a result, there will not be a smooth, uniform transition from one set of rules to another. Won't this cause market disruption? I think we have got part of that. Especially in the case of large group insurers who have employees in numerous States, not just the same State.

Mr. CLAXTON. I think it is—well, as a State comes on line with health care reform, what happens to the employees in that State is pretty straightforward and should not cause a great deal of problem. It is what happens if you have a few employees left in one State and most of your employees are in reform States. There are some potential problems there.

There are potential problems with any transition provision that I can think of that doesn't sort of have this whole thing bloom all at once, which would have a whole set of problems of its own. I think that if employers work with their insurers, they should be able to provide residual coverage through—for those smaller groups of employees left in other States. It won't be as convenient for them as they might like, but there are lots of—but there are lots of large employers now who have to arrange for coverage for groups of small employers—small groups of employees around the country and it is sort of an extension of that problem.

Mr. STEARNS. Thank you, Madam Chairwoman.

Mrs. COLLINS. Mr. Greenwood.

Mr. GREENWOOD. Thank you, Madam Chairwoman.

Mr. Claxton, this bill rests upon the definition of a lot of terms that are used. And in the general definition section that begins on page 323, there are lots of terms defined. There are some pretty fundamental terms that don't seem to be defined, or at least I haven't been able to find the definitions. So I would like to take a tack here that gets pretty basic, and that is to try to define some terms so we make sure we are talking about the same things.

Mr. CLAXTON. Sure, if I can.

Mr. GREENWOOD. The Health Security Act uses the term, financial solvency. For instance, there is a provision that the alliances can raise premiums only for the purposes, or at least for the purpose of ensuring financial solvency. And I would like to—

Mr. CLAXTON. And regulate premiums.

Mr. GREENWOOD. Pardon me?

Mr. CLAXTON. I understand.

Mr. GREENWOOD. They can exceed the prepared caps, as I understand the bill, if it is necessary to ensure financial solvency of a plan; is that correct?

Mr. CLAXTON. No. As I understand the provision that I think you are alluding to, it is that States do not regulate premiums under this system, except to assure financial solvency. The intent of that provision was to—was for the fact that when States take over a plan under rehabilitation or under an order for it to increase its premiums to do solvency, that would be an action of the State, and therefore it needed to be recognized as an exception.

Mr. GREENWOOD. So your position is that only in that instance can the State increase premiums.

Mr. CLAXTON. Yes.

Mr. GREENWOOD. And not if, for instance, there are fees set, but a State or an alliance does not choose to go to prospective budgeting whereby it can lower fees when utilization goes up, and if utilization does go up, there is no more speculative budgeting and fees are therefore not adjusted. You could risk insolvency, but at that point the State could not increase premiums, unless if it takes over—

Mr. CLAXTON. That is right.

Mr. GREENWOOD [continuing]. —The system?

Mr. CLAXTON. Well, in case of an individual insurer. The provision that you alluded to, as I understand it, is there to recognize the fact that sometimes States actually take control either directly or indirectly through an order of an insurer's operations because it is operating in a financially hazardous or a condition that is of hazard to its policyholders and you order it to increase rates.

It is for that purpose we recognized that a State could step in. It wasn't that they could do general premium regulation.

Mr. GREENWOOD. OK. So just, again, reiterate what was said so we are perfectly clear about this. If an alliance does not engage in prospective budgeting—

Mr. CLAXTON. For its fee-for-service plans.

Mr. GREENWOOD. If an alliance does not engage in prospective budgeting for its fee-for-service plans, and if utilization increases and fees are not adjusted down, at what point does the State look at that and say your premiums are insufficient?

Mr. CLAXTON. I think each year the alliance would look at its—at the fees and the alliance fee schedule and see if they are, if they are adequate or appropriate to assure that fee for service is viable in the marketplace and can be provided as is required by the act.

Mr. GREENWOOD. The State can't come in and say, alliance, you failed to do that, so we now adjust your premiums for you?

Mr. CLAXTON. The State does not adjust health plan premiums, no.

Mr. GREENWOOD. Unless it takes over the plan.

Mr. CLAXTON. That is true.

Mr. GREENWOOD. Let's go to another basic term and that is insurance. The term "insurance" is used in the context of the Health Security Act. Could you define how the term "insurance" is to be considered in the Act?

Mr. CLAXTON. There are some definitions—I just want to be thorough here. There are some definitions in title XI about that define health insurance and they define, well, health benefit plan, health insurance plan and health insurer. So you should look at those, as well.

In general, I think insurance is meant to mean the common law definition of it. There is some good cases on it, but generally it means to take risk for payment of an on—of a—to take risk for payment of an undeterminable amount in exchange for a premium, essentially.

Mr. GREENWOOD. Is a health maintenance organization (HMO) an insurance company or a provider in the context of the bill?

Mr. CLAXTON. It is an insurer. It is a health plan.

Mr. GREENWOOD. How does an insurance company handle risk and transfer risk?

Mr. CLAXTON. Insurers—well, health plans, if I can use that, just because I have been doing that for a few months now and I have a hard time doing otherwise, health plans each—

Mr. GREENWOOD. You are using those terms interchangeably now, health plans and insurance?

Mr. CLAXTON. And insurer. I am using health plan to refer to the entity in this case. Health plans offer a premium to individuals through the regional alliances or to people in corporate alliances. They get a payment from the alliance based on their per capita bid in exchange for agreeing to provide all the comprehensive benefits.

How they manage their own risk can be that they fully fund for it themselves, or that they have arrangements with providers where they share some of that risk. They can buy traditional reinsurance. And to some extent there is a reinsurance—a public reinsurance entity anticipated under the risk adjustment system, which would, in exchange for a reinsurance premium, exchange some risk with the health plans.

Mr. GREENWOOD. Is there a difference between the way an insurer and an HMO handles and transfers risk?

Mr. CLAXTON. There used to be a clearer difference. It is—there are plans that have participating providers and then there are plans that just pay whatever is reasonable and—I am sorry, whatever is medically necessary. If you—a few years ago you asked that question, most people would say insurers tend to pay on an indemnity basis, which means that they would pay for any medically necessary care that was within the benefit package that one of their enrollees received from any health care providers.

There are now some plans which even—even plans that we would normally call insurers, who establish exclusive networks where they would limit where you would go for services, they have a variety of different kinds of arrangements with providers on how they will pay them. The health plan, though, is always at risk.

If even in an HMO, if the providers all take a walk that next day, the HMO is not relieved of its obligation to provide whatever benefits have been promised under the insurance contract.

Mr. GREENWOOD. So under the bill we would view the HMO and the insurance companies as handling and transferring risks the same?

Mr. CLAXTON. Yes.

Mr. GREENWOOD. In the same fashion?

Mr. CLAXTON. Yes, primarily.

Mr. GREENWOOD. Should the same standards, then, apply to anyone accepting a transfer of risk in the health care system?

Mr. CLAXTON. There are the same type of regulations that should apply. I think, personally, some States choose to treat HMO's differently for either historic reasons or because they felt that a different type of regulation was appropriate.

Under the Health Security Act, we request the National Association of Insurance Commissioners to come up with risk-based capital standards which we would anticipate would look at all of the different types of entities and would establish capital—and the National Health Board can do this if the NAIC doesn't or if they disagree with the NAIC, to try to come up with a set of appropriate relationships between capital and risk. That would have to be based on the competitive environment that the health plan is engaged—is in, and part of that environment would be its—how much of the risk it is sharing with providers.

Generally, people in an integrated plan probably needs less capital. But an integrated plan that is the only one in an area might need less capital than one that has got—that is highly competitive with a number of other integrated plans. There is a number of factors that go into those decisions.

Mr. GREENWOOD. Those regulations would apply equally to insurers and HMO's?

Mr. CLAXTON. We would have to wait to see what the National Health Board does. I would—it is anticipated by the people who put this together that there would be a set of risk-based capital standards that would look at the continuum of people who are in health plans. And that is why it refers to health plans and not to the particular entities.

Mr. GREENWOOD. You used the term "reinsurance." How is that term used and what does it mean in the context of the Health Security Act?

Mr. CLAXTON. I think the only place where it is used, I may be wrong, but—well, there are several places where it is used. It is used in the risk adjustment section to apply to an idea of public reinsurance, which is a way that health plans can share the risk of certain high cost diagnoses. Similar, perhaps, to what New York has done when it implemented its community rating system.

We, in title XI, use the term "reinsurance" as way of an exception to say that in general these limits on premium increases don't apply to reinsurance. However, the Secretary is able to define an animal called the minimum premium plan or a partially insured, where some people would claim—where there has been some questions as to whether a plan that has a \$5,000 deductible and then insurance after that, is that a self-funded plan with a low stop loss

or is that an insurance plan? And so there is some definitions needed there.

Mr. GREENWOOD. Thank you, Mr. Claxton. Thank you, Madam Chairwoman.

Mrs. COLLINS. Thank you. Mr. Claxton, how long do you think that the transition period is going to last?

Mr. CLAXTON. We are hoping that it lasts until 1996 in some States, 1997 in others, and 1998 for all. I mean that everybody is in by 1998. To the extent—and I should say——

Mrs. COLLINS. Well, according to the bill, isn't it supposed to last just 2 or 3 years?

Mr. CLAXTON. That is 2 to 4 years. I mean it—depending on when you enact it, that it is part of 1994, part of 1995, part of 1996 and part of 1997. And so that is a number of years. And in some States——

Mrs. COLLINS. Do you think that it is possible that the implementation of the alliance system of health care might take longer than you currently expect?

Mr. CLAXTON. We believe that the implementation that we have under the act is appropriate and can happen on the time schedule we have put in place. What I would like to say, though, is that to the extent that whatever is enacted is a longer transition period, then you would—then you might start to consider as part of interim insurance reforms moving the market towards, towards community rating in a more gradual fashion.

If you have a longer period, you don't—you can—the dysfunction that can exist can be addressed more incrementally. The reason that our interim insurance reforms are relative drastic is because for a number of States we are talking about a very short period of time.

Mrs. COLLINS. Well, do you think that the transition rules are adequate in the event of a longer transition period?

Mr. CLAXTON. My personal belief is that in the event of a longer transition period, it would be better to move—it would be better to—we would have the justification to create some new oversight that could move the market more gradually into community rating. But I think they are adequate, but I think you might want to do some additional things if you had a longer period.

Mrs. COLLINS. OK. Section 11001 directs the Secretary to issue regulations regarding the transfer of health insurance policies from one insurer to another. The question is how long do you think it is going to take the Secretary to issue these regulations?

Mr. CLAXTON. I believe—as I said, the act authorizes that all regulations can be issued on an interim final business basis. I think, as Mr. Stearns, pointed out, this is a terribly important issue. We would anticipate doing this as quickly as possible. We can probably use some of the State laws in this regard as a good model.

Mrs. COLLINS. Why does 90 days stick out in my mind?

Mr. CLAXTON. Ninety days is the period of time that the Secretary has to issue regulations as to how the rating provisions would work, as I remember.

Mrs. COLLINS. But hasn't this sort of been an ongoing discussion over the last several years? I am thinking of the NAIC. It seems

to me they have been arguing with similar regulations for the last couple of years.

Mr. CLAXTON. Yes, and they have—and in their small group reforms they have some provisions that deal with assumption reinsurance, which is the transfer of blocks of business. And those might be—those might be appropriate here and certainly can last during the interim until the Secretary issues regulations. What we need—what we wanted to do is have the flexibility to make sure that we didn't cause the types of disruptions that Mr. Stearns was pointing out.

Mrs. COLLINS. Part three of title X establishes a commission to study the integration of workers' compensation and automobile insurance into a new health care system. Right now the report—they report only to the President. It would seem to me that it might be useful for the commission to report its findings to the Congress as well as the President. What are your thoughts on that?

Mr. CLAXTON. Well, I certainly—whatever report was made available would be available to Congress. Our thinking was that whatever the commission recommends will need to be enacted by Congress, and therefore the information would naturally be made available to them.

I mean certainly it is appropriate that they have the benefit of whatever this commission comes up with, that you have that, excuse me.

Mrs. COLLINS. I think it might be helpful if we review the report before it gets here. Sometimes it helps us a lot before we get ready to act on it if we have the report in hand well in advance, or as quickly in advance as we could get it.

Mr. CLAXTON. We certainly have no objection to that. I mean our goal was to have an open and fair hearing of all of the issues related to what is a difficult issue.

Mrs. COLLINS. Automobile insurance and worker compensation insurance are very different lines of business and I am wondering if it would be useful for the commission to study them separately. What are your thoughts?

Mr. CLAXTON. I think that would be very appropriate. I think the assumption was that much—there are some things which are common issues and they may need to be studied together. There are other things which are certainly separate between the two systems and probably should be studied separately.

Mrs. COLLINS. H.R. 3600 leaves a substantial amount of enforcement in the transition period to the State insurance commissioners. And as you know, this subcommittee has expressed concern that State insurance commissioners don't currently have enough resources to adequately regulate the insurance.

Do you think they have sufficient resources to implement and enforce the new rules under title XI?

Mr. CLAXTON. In the administrative cost of implementing health care reform, there is some money that is thought about for providing technical assistance to the States and preparing them for reform. I think part of that could be available for the purpose of making sure that the transition provisions go smoothly.

In addition, we have tried to keep these provisions relatively straightforward and to the extent possible to rely on an audit trail

so that, so that there is much—so that much of what the States would have to do under this could be done by contracting with vendors if they don't have people on their own staff.

Mrs. COLLINS. Thank you.

Mr. Stearns.

Mr. STEARNS. Thank you, Madam Chairwoman. I was here during the Clean Air Act of 1990 and Congress mandated literally hundreds of implementing regulations, rulemaking. To date, the Environmental Protection Agency has missed almost every deadline in the bill. Why do we think any of the agencies under the Clinton health care plan will face any better behavior?

Mr. CLAXTON. I can only speak for my agency and that is we are—we are committed to getting these insurance reforms out as quickly—the regs for these insurance reforms as quickly as possible. I did talk to the administrator who would be doing it about that. We recognize that these interim rules would have to affect virtually every insurance plan in America and we need to bring stability to the market as soon as possible.

I can say that if we don't have quick rules or if we ignore this problem, we will see the problems that we saw in a few States where insurers will say, well, the reforms take effect in a few months. I am going to start weeding out my bad risks now, and it is going to be real hard to raise that coverage during the interim period. We can't have that.

Mr. STEARNS. Mr. Claxton, in your own agency, let me ask you a question. Have you met all the deadlines for implementing the regulations? Can you say with assurance here today that you have met all your deadlines?

Mr. CLAXTON. I have no idea. I assume not, but I have no idea.

Mr. STEARNS. Well, I think you are human, I think you probably haven't. But that is the point. It would be so much dysfunction in the marketplace while we are waiting for these implementing regulations to come in, and yet we have seen from other government programs, particularly the Clean Air Act, that they never met the deadline. So I think that is a real problem that all of us would be concerned about.

Let me shift gears here and reading through some of this bill, you used the word "risk" a lot. And I have just gotten a litany here of ways you have used it. For example, in section 1541, you say risk adjustment, risk categories, risk factors. And you talk about behavioral risk factors.

You talk about risk assessment in high risk populations. Of course, you use the word financial risk a lot. Then you would use the word bearing risk and insurance risk, then risk management, excess risk percentage, extra risk proportion and average demographic risk, risk sharing contracts, national transitional health insurance risk pool.

Let me just ask you to define just a couple of these, because you can imagine what the staff and myself, going through this and trying to understand. Let's take the one in section 1127. You discuss behavioral risk factors. Can you tell me what this term means and what elements comprise the factors?

Mr. CLAXTON. I don't, I am sorry, I don't have it in front of me. Usually that term would be used to refer to—

Mr. STEARNS. Because you know you have financial risk, you have management risk, behavioral risk, just go on and on and on.

Mr. CLAXTON. Behavioral risk would have to do with the—the change of insurance risks that would occur with respect to a person due to circumstances that would be under their control, behaviors that they can control. That is how I would normally, that is how I would normally define it.

I would be happy to look at the act and then read it and get back to you if I have done that wrong.

Mr. STEARNS. Well, let me say in section 1624, and I know you can't memorize the bill, I understand that. I think the point I am trying to make is that you used the term "risk" in so many different ways, if I was a person trying to comply with this thing, you know, I would wonder what are the components that make up this one. And it is not clear in the legislation.

For example, in section 1624, you discuss excess risk percentage. Now, that is a glaze eyes. Excess risk proportion and average demographic risk. You know what I mean? You are having to look at these and can you tell me what each of these terms mean right now? Can you separate each of these three? Excess risk percentage, tell me that one, for example.

Mr. CLAXTON. The excess risk percentage is the difference—if you look at a large employer—well, I am sorry. I will have to get back to you on that. I am trying to remember the term.

Mr. STEARNS. OK. Let me—staff has suggested I give you what we have here, and I think before we go on forward on this bill, we should have a good understanding what the definitions are so that all people—so we have got about 14 of them.

Mr. CLAXTON. We would be happy to define these terms for you. I don't have a problem with that. I just, at the moment, don't remember the difference between each of these terms.

Mr. STEARNS. OK.

Let me shift to workers' compensation and auto. Will such things as rehabilitation be considered medical or indemnity, who will make that determination?

Mr. CLAXTON. The general cut we were trying to make here is that if it is medical services, it would be medical. If it is things like vocational and rehabilitation, it would not be medical. I think that if—I believe that this provision would be something that the Secretary of Labor would have to define more fully through regulations if we were to get that far.

Mr. STEARNS. Well, who is going to make the determination? Is it in the regulation? Have you specified who is going to make the determination?

Mr. CLAXTON. The Secretary of Labor determines regulations to carry forward this section.

Mr. STEARNS. And this is all specified. We all understand this before, right now?

Mr. CLAXTON. No, we don't understand it right now. We would need to have it done through implementing regulation. I think that is right.

Mr. STEARNS. Well, you see how that implementing regulation didn't get put in.

Mr. CLAXTON. No, no, I understand that provision. If I could make a point about workers' compensation. As we said before, we have had a great number of discussions throughout the task force period on this particular issue with Labor and with business. What we have tried to do is establish a framework here. As with many of the other provisions of this bill, it is going to have to be fleshed out to some extent by our discussions with you and, hopefully, by the interested parties getting together here.

What we have tried to do is give you a very good basis for having that discussion. It doesn't mean that we have answered every particular question in the act as it is written down.

Mr. STEARNS. This is dealing with workmen's compensation. What is the role of the case manager in the Clinton plan versus the insurer or employers? What steps will be taken to ensure that the plan case manager will be working in the best interest of getting the employee back to work as quickly as possible when there may entail more costly and intensive rehabilitative treatment which may not be in the interest of the case worker's direct employer? You see how that would work at cross-purposes?

Mr. CLAXTON. No, I have heard that, and we have discussed that at great length with both representatives of employers and insurers and with Labor. One of the—again, if you look at the system we have today, in about half the States, the employee can go wherever they want and there is no particular control by the workers' compensation insurer that is different than what we have today.

In other States, the insurer or the payer has somewhat more control. What I think is appropriate here is that, first, the case manager, what we tried to do was have the case manager work with the employer and with the workers' compensation insurer to—and specifically states that they are supposed to work on getting people back to work when it is medically appropriate. It is not necessary—the health plan, because it is getting paid fee for service, quite frankly, has no incentive not to provide services as rapidly as need be in order to get someone back to work.

In addition, what we tried to do with these protocols is put together, is to try for the first time to get some sense of what standards we should use to determine if the back to work was appropriate. And finally, just as they have today, we have preserved the right of the workers' compensation insurer to not pay for something if they think it is not appropriate, if they think it is not medically necessary or covered under the terms of the act, or as they have today, to go to whatever State forum there is to protest the treatment an individual is getting.

And finally, if they—if the workers' compensation insurer or the employer want to go to the individual and say I can provide service for you in a better place and that individual agrees, they are free to do so under the act.

Mr. STEARNS. Well, I think we are just worried about the employer's indemnity clause. He has got to continue to pay this money to the employee and the protocols are not set up and this thing is going on.

Mr. CLAXTON. Again, I understand that, but what I was saying earlier is that in about half the States now the employer doesn't control this either, and there is no evidence that the health care

costs are any lower or the total costs are any lower in States where the employer controls this than where they don't.

Mr. STEARNS. This is a question. What numbers or studies has the administration used in its assumption that merging workers' compensation, auto, medical, into the Clinton health plan will ultimately decrease costs?

Now, I start out by saying you can supply this subcommittee the financial assumptions that you made in 5 working days or if you would like to take a crack at it, but obviously we can't do it in 10 minutes. But it is a critical, you know, critical to understand what the assumptions are that you have made, the administration's.

In Energy and Commerce, we have asked for all the assumptions behind the health care bill. We have yet to get them.

Mr. CLAXTON. I understand that. In general, on workers' compensation, we have not assumed savings in terms of the numbers. What we have assumed, I should look if there is anything in the national health expenditure data on that, but in general what we have assumed is only—we would be looking at the rate of growth in the fee-for-service fee schedule that would exist on the health care side and the constraints that exist towards that, and realize that is what is going to be used on the workers' comp side. That has got to exist. That, almost by definition, has to result in lower fees and to some extent into savings.

These other provisions are more speculative as to whether or not you think there is less fraud if you take some of the bad providers out of market. We would argue that there is. But this isn't sort of a cornerstone of the financial provisions of the Clinton plan.

Mr. STEARNS. So you will give us all the assumptions?

Mr. CLAXTON. Yes.

Mr. STEARNS. Thank you, Madam Chairwoman.

Mrs. COLLINS. Mr. Greenwood.

Mr. GREENWOOD. Thank you, Madam Chairwoman.

I am going to return to this very tedious line of questioning. We ask you to be the Noah Webster for health care, to carve all of these terms into granite for all time. I don't want you to feel under any pressure.

To go back to my questions about reinsurance, in section 1541, B-1, we have the following language: "In general, the methodology developed under this section may include a system of mandatory reinsurance, but may not include a system of voluntary reinsurance."

What does that statement mean?

Mr. CLAXTON. Under the State—under—if you look at the State small group reform efforts, there are some States that have what they call voluntary reinsurance and some States that have what they call mandatory reinsurance. Again, this is public reinsurance. It is not sort of the private arrangements that insurers arrange with their own reinsurers.

Mandatory reinsurance means that every health plan in an area is part of that reinsurance system and they owe into it either through premiums or through assessments. Voluntary reinsurance means that some insurers can choose, as is in some States, I couldn't name which ones, where some insurers could choose to

guarantee issue and take all the risk and not participate in the broader risk pooling that occurs through reinsurance.

Because we are using reinsurance as a method of risk adjustment here, and we are trying to get at the adverse selection that could occur against some health plans during a guarantee issue community rate open enrollment, we felt it had to be mandatory because that is what is essentially the spreading of the risk of those high cost cases.

Mr. GREENWOOD. OK. Reinsurance also is used in section 1203-G: "If the risk adjustment and reinsurance methodology developed under section 1541 includes a mandatory reinsurance system, each participating State shall establish a reinsurance program consistent with such methodology and any additional standards established by the board."

What does that statement mean and in particular what does the term, "establish" mean?

Mr. CLAXTON. The risk adjustment and reinsurance methodology is developed or established, if you want to use that term, by the National Health Board. So there is a methodology that is the same everywhere. Although the factors may—the weights of the factors may vary locally.

What this is saying is that as a condition of a State—if as part of the risk adjustment and reinsurance methodology that the board develops they choose a system of mandatory reinsurance as part of that, which we could anticipate during the early years, that as part of their conditions—as part of becoming a certified State, a State would have to develop such an entity, much like some of the States have done under the small group insurance reforms that they have now.

Mr. GREENWOOD. OK. If States act as reinsurers, what methodology will States use to cover risk?

Mr. CLAXTON. The reinsurance entities that are anticipated are self-supporting in the sense that they take a certain premium—they take a certain money from health plans, either through premiums and/or assessments, and they pay back out of the money they take in based on the—on certain—well, either on a percentage of claims or certain diagnoses.

We didn't specify—that is up to the national board to determine exactly what type of reinsurance they would do. These things are not meant to be at risk in the sense that there is—that there is a separate stream of money.

Mr. GREENWOOD. Is there a capital base that underlies the reinsurance system established by States?

Mr. CLAXTON. No, again, because it is not at risk. It only pays out what it brings in through assessments or premiums. So it doesn't—if it doesn't have risk, it really doesn't need a capital base. It may need to do an initial assessment to get started on a cash flow basis, or that may come in through premiums.

Mr. GREENWOOD. What participants in the health care system will use reinsurance facilities? How will reinsurance apply to each participant? What will be the impact on HMO capitation systems?

Mr. CLAXTON. In terms of enrollees, folks, they won't know it exists necessarily. So this is really a way of sharing risk among health plans. Again, we have not specified in the act exactly how

the reinsurance would look. That is up to the National Health Board.

Presumably, the health plans would pay in either on the basis of some percentage of premiums they get in or some premium or some assessment and would receive money back when they treat certain—when certain individuals are among their enrollees, either high cost cases or high cost diagnoses like AIDS, for instance.

Mr. GREENWOOD. So financial solvency requirements apply to State-established reinsurance systems?

Mr. CLAXTON. No. Again, I don't know what the National Health Board would ultimately do. They could come up with a reinsurance system that is different, that would be what we envisioned, but what we have envisioned is more operating like some of the State reinsurance systems that exist now.

Mr. GREENWOOD. OK. Does the Health Security Act envision a role for market-based reinsurance firms?

Mr. CLAXTON. I think it is still the case that some health plans may want to lay off some of their risk and so there is no reason—I would expect that some health insurers would continue to purchase excess loss or stop loss coverage.

Mr. GREENWOOD. OK. Let's turn to another term, the term, "guarantee fund." How is the term "guarantee fund" used and what is its role in the context of the Health Security Act? What are its sources of funds?

Mr. CLAXTON. The Health Security Act requires that each State—each State has a life and health insurance guarantee fund now. The act requires those States to amend their funds in a couple of ways.

The way guarantee funds exist now is if an insurer becomes insolvent and is taken over by the State, and it is—the State takes over whatever assets that are there. And between the residual assets of the insurer and money from the guarantee fund, which is essentially a participation of other insurers in the marketplace, it pays out the claims to the covered individuals up to whatever limits there are on guarantee fund coverage and whatever limits there are on assessments to the rest of the industry.

We have changed that to some extent because individuals do not bear the risk of insolvency. Covered individuals cannot be billed by health care providers in case of insolvency. Therefore, therefore, if an individual is in a health plan that becomes insolvent, that individual is moved to another health plan, is given an opportunity to enroll in another health plan. There is, however, when an insolvency occurs, some money owing both to health care providers for the period of time perhaps before the insolvency, and there may be some series of weeks or maybe even a few months, we hope not, during which we had to move these people from one place to another and they are going to still get health care services.

So what we have done with the guarantee funds is to say that now the guarantee fund will pay health care providers for the services that they render to participants of insolvent plans.

Mr. GREENWOOD. Why wouldn't I, if I may interrupt you, form a group of providers, intentionally low ball my fees in order to be competitive, allow myself thereby to become insolvent and get paid anyway?

Mr. CLAXTON. Well, for one thing it is a one-time problem, and which makes it seem like a very strange market activity, quite frankly. Second, I am not sure a State would certify a plan that they thought of as tremendously undercapitalized and they would at least have to come up with the capital to get in the market in the first instance.

There is an issue which could be explored and probably should be explored as to whether or not integrated health plans—the providers of integrated health plans should be provided the same level of protection under State guarantee funds. Most States now, HMO's are not part of the guarantee fund and that has caused a number of problems.

We tried to move all health plans into the guaranteed funds. One could argue that there should be different protections for certain providers who are integrated into plans at certain levels and that would certainly be an appropriate thing to consider.

Mr. GREENWOOD. OK. How are fiduciary interests defined in the context of the Health Security Act?

Mr. CLAXTON. They are defined in a couple of ways. One is that certain ERISA provisions are addressed and ERISA sets—has some statutory fiduciary provisions, and I cannot remember in every way that they might be addressed by the act.

In other places, and there might be some others that I am not aware of, the act requires the Secretary of Health and Human Services to establish fiduciary standards for health care appliance licenses. And what they would mean—and cash management standards as well. And what that means is it would be requirements similar to the ERISA requirements that whoever is on the board of an alliance or whoever is a service provider to an alliance or is otherwise connected with an alliance would have to handle any assets that they were actually in control of in the best—only in the interest of the participants, in this case the alliance members. That is generally what is meant by that.

Mr. GREENWOOD. When a fiduciary role is performed by the alliance and State and Federal governments, what are the fiduciary relationships of each in the health care system? Thirty seconds or less.

Mr. CLAXTON. The fiduciary standards, the fiduciary role of the alliances is that they are collecting premiums from employers and individual families and passing them on to health plans. They are, to some extent, holding the money of others and therefore should be required to protect that money and act in the best interests of the people that they are holding it for and only in those peoples' interests, and should not in any way act in their own self-interest.

The States and the Federal Government do not—the State could hold some—have some sort of residual fiduciary interest in the sense that it oversees the alliances.

Generally, you don't apply the same—you look at different things other than fiduciary standards when you deal with public entities, although they certainly should have the same motivations and purposes there. And then there is a series of cash management rules that will have to apply to the alliances to actually control their access to the money and how much discretionary—how much discretion they can use with respect to any of that money.

Mr. GREENWOOD. Thank you, Madam Chairwoman. Mr. Claxton has been very competent and forthcoming with his responses. We have some definitional questions that Mr. Stearns has raised and if I may, I would just simply like to ask that we have the opportunity to submit these to Mr. Claxton in writing. Due to the fast track we are on, we would like to have your responses within 5 working days.

Mr. CLAXTON. Sure.

Mrs. COLLINS. Thank you very much for your very helpful testimony, Mr. Claxton. We very much appreciate it.

Mrs. COLLINS. Our next panel will be Mr. Cecil Bykerk, who is the senior executive vice president and chief actuary for the Mutual of Omaha Companies, and Ms. Alissa T. Fox, who is the executive director for the Blue Cross and Blue Shield Association. Won't you come forward, please?

Why don't we begin with you, Mr. Bykerk.

STATEMENTS OF CECIL BYKERK, SENIOR EXECUTIVE VICE PRESIDENT, MUTUAL OF OMAHA COMPANIES; AND ALISSA T. FOX, EXECUTIVE DIRECTOR, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. BYKERK. Madam Chairwoman and members of the subcommittee, thank you for the opportunity to testify on behalf of Mutual of Omaha on this important topic of transitioning.

Mutual of Omaha supports comprehensive reform, including guaranteed coverage accomplished through an employer and individual mandate. Because we are the largest writer of individual and family insurance and a major group writer, we bring a unique perspective.

We commend President and Mrs. Clinton for focusing the public's concern on health care reform and we strongly support their goal of achieving universal coverage. We believe that employer and individual mandates are key elements of successful reform for the health care system.

Health care reform will have a major impact on one-seventh of our economy, so it must be done right the first time. The transition must be orderly. To do too much too quickly in the transition would have serious consequences for consumers. Unfortunately, the timetable for transition is unrealistic and the rules are extremely complex.

We agree that transition and insurance reform rules should apply to all health coverage, including ERISA plans. Additionally, individuals and groups should not have to worry about being canceled.

We don't cancel individuals now and we support reform prohibiting cancellation of small groups.

The act, however, contains no means for a health plan to convert a policy once all Americans are insured under the comprehensive benefit package. Nor does it provide a means for insurance companies to sell or terminate blocks of coverage in order to get out of the business during the transition.

We recommend some provision explicitly allowing for automatic conversion to the new benefits and the ability to cancel policies under a plan that has not been certified by the State.

The rating section intends to lock in the relationship between current premium rates. These rules are so extremely complex and difficult to interpret, however, they would be impossible to implement, much less enforce.

Second, the rules put carriers who previously sold individual, small group and large group business at a disadvantage compared to carriers selling only one or two lines of business. This could cause market dislocation as persons with better risks would move to the new carriers, probably with lower rates, discussing the older carriers' business to enter a cost spiral. This would cause price hikes for remaining policyholders and potential solvency concerns for older carriers.

Premium increase limitations set by the Secretary could cause severe problems, especially if insurance reforms are implemented without the ability to update existing policies.

It is unfortunate that the portability protection afforded to groups was not extended to individuals. We would support giving individuals the ability to change carriers as long as there is a 12-month preexisting condition limit for first-time insureds.

While we have supported State high risk pools, and I personally serve on three high risk pool boards, we are not sure that using a Federal high risk pool to ensure access makes much sense in this context. A Federal pool would impose an undue burden on the States requiring the 27 States currently with risk pools to make significant changes and the remaining States to implement a mechanism only to have it all dismantled in 1997.

Another way to ensure access to coverage during the transition is to build on the success of 40 States that have already enacted small group reform. Even in the absence of a mandate, it is possible to guarantee issue coverage to individuals during a once-a-year open enrollment period, and to have year-round guaranteed issued coverage to small employers.

If certain individual and small group reform measures were instituted, rather than building a large temporary system, the transition period would move toward the fully implemented reform goals at a quicker pace.

We strongly recommend against implementing full insurance reforms either before or in the absence of universal coverage. Our experience in New York with reforms that lacked a mandate illustrate the serious consequences that could follow.

When pure community rating was instituted, premiums increased for about 60 percent of individually insured persons. The number of Mutual of Omaha individual insurance policies dropped by over 30 percent within the first 9 months of the New York system.

In a random survey of our lapsing policyholders, we found that more than half lapsed due to cost. And nearly half went without subsequent coverage, most of whom were younger people.

We are not suggesting that Congress forego insurance reform, only that insurance reforms must occur lock step with universal coverage through a mandate.

In conclusion, we have observed serious flaws in the transition section. We want the final legislative product to provide an orderly transition and not make the same mistakes that were made in New York. We would be happy to contribute in a positive way to make the transition for consumers. Thank you.

[Testimony resumes on p. 133.]

[The prepared statement of Mr. Bykerk follows:]

Cecil Bykerk, FSA, MAAA

Senior Executive Vice President and Chief Actuary

The Mutual of Omaha Companies

Madam Chairwoman and members of the subcommittee, I am Cecil Bykerk, Senior Executive Vice President and Chief Actuary, of the Mutual of Omaha Companies in Omaha, Nebraska. I also am a Vice President of the Board of Governors of the Society of Actuaries and a member of the American Academy of Actuaries. Thank you for the opportunity to testify on behalf of the Mutual of Omaha Companies on the important topic of transitioning into a reformed health care system.

The Mutual of Omaha Companies provide more individual health insurance to American families and individuals than any other company and is one of the top ten group insurance carriers in the United States. Within our group operations we sell both small group and large group coverage, as well as participate in a number of Federal Employee Health Benefit (FEHB) Plans and the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) program. We have administered state high risk pools and currently serve on several Boards of state high risk insurance plans. I personally serve on three state high risk plan Boards.

For the record, the Mutual of Omaha Companies support comprehensive health care reform including guaranteed coverage accomplished through an employer and individual mandate. We also support reform of the individual and small group health insurance markets, consistent provider reimbursement and other major reforms which I will outline later in this testimony. Because we are the largest writer of individual and family insurance in the United States, we bring a unique perspective that will be reflected in my testimony.

The purpose of my testimony is to:

- o Describe the transition rules as proposed in President Clinton's Health Security Act (H.R. 3600) and discuss the impact of these rules on health plans and consumers; and,
- o Outline possible scenarios for transition and fully implemented health care reform.

THE HEALTH SECURITY ACT TRANSITION RULES AND THE IMPACT ON HEALTH PLANS AND CONSUMERS

The Mutual of Omaha Companies commend President and Mrs. Clinton for bringing the public's awareness of the need for health care reform to the forefront and we strongly support their goal of achieving universal coverage by providing a standard benefit package to all persons. We believe that employer and individual mandates are key elements of a successful effort to reform the health care delivery system.

By way of illustration, there is a very successful local restaurant chain in Omaha called the Garden Cafe that serves delicious home-cooked meals and great desserts. They display a sign for their staff that says, "When everyone works - it's easy". A variation on this slogan would apply to health care reform - when everyone is covered - it works. As you may know, there are aspects of the Clinton bill, such as mandatory health alliances, pure community rating and premium caps, that we cannot support. We believe this level of change in regulation is unnecessary if mandated coverage and insurance reforms are enacted. Nevertheless, we support many aspects of the Health Security Act, and we are eager to see a swift transition to universal coverage that can be accomplished through an employer and individual mandate.

The Clinton Transition Plan

Under the Health Security Act, health alliances and health plan rules do not take full effect until 1997. Additionally, universal coverage, brought about by individual and employer mandates, is not effective until January, 1998. Between the date of enactment of the Health Security Act and full implementation of the health alliances and health plans, a transitional period will be instituted with specific rules for insurance companies. I will outline each of the transition rules and discuss the effects of these rules on health plans and consumers, in the order in which they are presented in the Health Security Act. It is our belief that any transitions rules should impose requirements that: 1) can be met with reasonable effort; 2) apply to all providers of health plans (HMOs, etc.); 3) protect current insureds from the costs of risk selection; 4) provide uninsured individuals with prompt access; and, 5) protect the solvency of companies.

Time-Frame of the Transition

Within 90 days of enactment of the Health Security Act (and in many cases on the date of enactment), many of the transition rules take effect. These rules will preempt state law, if the state law directly conflicts with the federal transition rules. The new Secretary for Insurance and Health Plans, as defined by the Health Security Act, and the Secretary of Labor will work with the states to enforce these transition rules. The rules include guaranteed renewability of coverage, limitations on the use of preexisting conditions, rating restrictions and other aspects of insurance reform.

Impact on Health Plans and Consumers

This provision presents an impossible time-frame for implementation, not only for health plans to comply with the transition rules, but for the states who must enforce the rules. It likely will take the states at least 90 days to even determine which state laws are preempted by the federal reform. We understand the Administration's eagerness to begin reform; however, the complexity of the transition rules preclude an immediate or even 90-day time-frame for implementation after enactment.

Who is Affected Under the Clinton Plan

The Health Security Act transition rules apply to all providers of health coverage including: HMOs; individual; small group and large group health insurers; and self-insured (ERISA) plans. Currently, each of these types of insurance, with the exception of self-insured plans, is regulated by separate state statutes which may vary considerably from state to state. Self-insured plans are regulated by the federal government under the Employee Retirement Income Security Act (ERISA).

Impact on Health Plans and Consumers

We agree that transition and insurance reform rules should apply to all carriers and forms of health insurance coverage. To exclude any group invites that group to benefit at the expense of the rest of the system. However, because of underlying differences between large multi-state employer groups and individually insured self-employed persons, for example, these lines of business should not necessarily be treated identically during or after the transition period.

Additionally, the differences among state laws and regulations in this area will further complicate the transition issues and process.

Prohibition of Termination (Guaranteed Renewability)

Effective on the date of enactment, insurers and HMOs may not terminate (or fail to renew) coverage for employer plans or individual policies except for:

- o nonpayment of required premium;
- o fraud; or
- o misrepresentation of a material fact related to an application for coverage or claim for benefits.

Impact on Health Plans and Consumers

We agree that individuals and groups should not have to worry about having their coverage canceled. We don't cancel individuals now. In addition, we support small group reform that would also prohibit cancellation of small groups.

The Health Security Act, however, contains no provision for insurance companies to sell or terminate blocks of coverage during this period. Any prudent legislation must permit companies to exit a market, since forcing companies to remain in a market when it is not fiscally sound (e.g., if the company were incurring heavy losses) could drive those companies into insolvency. Hence, we strongly advise some provision for exiting the market, perhaps with a stipulation that a carrier may not reenter that market for five years, as has been implemented for small group business in approximately 20 states.

The Transition rules also provide no means for a health plan to cancel a policy after the final reform is implemented and all Americans are insured for the comprehensive benefit

package. There are a number of persons who might feel compelled to retain their old coverage, even after obtaining the comprehensive benefit package under the new system, resulting in duplicative coverage. Without such a provision for cancellation, health plans would violate the law both for insuring persons and for canceling persons under old policies. We recommend some provision explicitly allowing for automatic conversion to the comprehensive benefit package or the ability to cancel the insured person, if the health plan were not certified by the state.

Acceptance of New Members (Guarantee Issue)

Insurers who provide a group health insurance plan that is in place on the effective date of this Act must accept all individuals and their eligible dependents who become full time employees of that employer.

Self-insured plans also must cover all eligible employees and dependents in their plans.

Impact on Health Plans and Consumers

Acceptance of new members is a key feature of small group reform. The Mutual of Omaha Companies generally support small group reform during the Transition period. Ideally, these reforms would be in the context of comprehensive small group reform that includes a reinsurance pool.

Rating Restrictions

We have decided the rating rules of the Transition Section represent one of the five great mysteries of the universe. I will describe the rating rules as best we understand them at this time.

Rating restrictions outlined under the Transition Section apply only to health insurers (which exclude HMOs and self-insured (ERISA) plans). Specifically, the restrictions apply:

1. to changes in premiums occurring on or after the date of enactment of this Act, for groups and individuals covered as of that date; or
2. for groups and individuals covered after the date of enactment, to changes in premiums after the date coverage begins.

During the Transition period, premium rates will be calculated based on three sectors of current business. These sectors are defined as:

- o Individual;
- o Small Group (employers < 100 lives); and,
- o Large Group (employers \geq 100 lives).

Calculation of the Reference Rate

All new and renewal premiums are based on a "reference rate", which will be calculated for each sector. This rate, when applied against the rate factors, must approximate the average premium charged to individuals and/or groups in that sector, as of the effective date of the Act. Reference rates may be adjusted for: age, family composition and geographic area characteristics of that sector.

New Business Rates

There seems to be an implicit assumption that all new business would be priced using the rate factors for each sector.

Renewal Rates

In-force premium rates may be modified due to changes in group or individual characteristics. These characteristics include:

- a. Changes in the number of individuals covered under the plan; or
- b. Changes in group or individual characteristics including, age, gender, family composition or geographic areas. Changes may not include health status, claims experience or duration of coverage under the plan;
- c. Changes in the level of benefits under the plan; and
- d. Material changes in terms and conditions of coverage.

Health insurers that increase premiums are also required to develop a single set of rate factors for each sector. The rate factors are used to calculate changes in premium that relate to changes in group or individual characteristics, changes in benefits or material changes in the terms of coverage.

Rate factors developed by insurers must relate to reasonable and objective differences in demographic characteristics, in the design and levels of coverage and in other terms and conditions of a contract. Rate factors may not relate to expected health status, claims experience or duration of coverage of one or more groups or individuals. Even in applying rate factors, resulting changes in premium may not reflect any change in health status, claims experience or duration of coverage, with respect to any specific employer or individual covered under the plan.

For changes in premium rates that relate to a change in the number of persons covered under a health insurance plan, the premium change is calculated by applying the reference rate (for that sector) to the rate factors applicable to the persons who joined or left the plan. In other words, if a sixty year-old man left the plan and a twenty-two year-old woman joined the plan, the rate factors for persons with these characteristics would be applied to the reference rate for that sector to calculate a new premium for the group. By the way, the group's premium probably would go down as a result of this change.

In-force premiums also may be changed because of health care costs and utilization. In general, health insurers that increase premiums because of increases in costs or utilization

must apply the same percentage increase to all plans in all sectors. Health insurers may vary the percentage increase among plans in the large group sector, based on the credible claims experience of particular employers, as long as the weighted average of increases for all plans in this sector are equal to the percentage increase in other sectors.

Premium changes related to health care costs and utilization may be applied at a national level or may vary based on a geographic area. Area variations may be applied only if the areas are sufficiently large to provide credible data on which to calculate the variation.

The cost and utilization increase rules do not apply to premium rates that are subject to prior approval by a state insurance commissioner or a similar official. The Secretary also is authorized to grant exceptions to the limitations on rate increases to accommodate state insurance reform efforts, if necessary, to permit a state to narrow the variations in premiums among health insurance plans within a sector. The Secretary may also grant other exceptions as necessary to enhance stability of the health insurance market and continued availability of coverage.

An insurance company may petition for an exception from the transition rating rules if it can demonstrate that these rules would threaten the financial viability of the insurer. The insurer must offer an alternative method for increasing premiums that is not substantially discriminatory to any sector or to any group or individual.

Insurers must obtain prior approval for proposed premium increases for the individual and small group sector if the proposed premium increase exceeds a percentage specified by the Secretary.

Impact on Health Plans and Consumers

It appears that the intent of the transition rating section of the Health Security Act is to lock in the current premium rates, as they apply to any given individual and group. Recognizing that changes do occur in characteristics and in the number of participants, as well as in health care costs and utilization, a method was developed in an attempt to maintain the current relative spread of premiums among sectors and thus prevent circumvention of the intent of the law.

To begin, as I said earlier, this section of the transition language is extremely complicated and subject to multiple interpretations. If I am interpreting it correctly, the calculation of the reference rate and the rate factors would be an extremely difficult job. (There are easier ways to accomplish the same goal, as I will discuss later in my testimony.)

Secondly, the rules put carriers who previously sold individual, small group and large group business at a disadvantage compared to carriers selling only one or two lines of business.

New carriers are positioned even more advantageously, since a new carrier will start out with a clean slate and will not be restricted by the experience of old blocks of business. On

the other hand, a long-standing carrier would be limited in its flexibility in pricing new business due to the necessity of keeping a certain relationship with the old business. This could cause market dislocation as persons with better risks would move to the new carriers (with lower rates), causing the older carriers' business to enter a "cost spiral". This situation would cause price hikes for remaining policyholders and potential solvency concerns for older carriers.

Under the transition rules, certain rating rules do not apply if the underlying rates are subject to state rate approval. The definition of "rate approval" has been a long-standing point of dissension between insurers and many insurance departments. Insurance departments typically maintain that rates are merely "reviewed and filed", or disapproved. Carriers generally feel that they should not sell business associated with new rates until the state department of insurance has duly "reviewed and filed" them. In addition, rates for some types of business are approved while other types are not. We do not know how the proposed system would operate in that situation.

Given that employer and individuals renew throughout the year, it also is also unclear how a carrier must comply with the "even application" section of the Clinton plan.

The application of premium increase limitations set by the Secretary could cause severe problems for some carriers. In the case of individual policies, most of which are fee-for-service, the carrier frequently has less direct control over charges and utilization. Artificially imposed rate increase limitations would most likely not take this into consideration. While we strongly oppose premium rate caps of any sort, we especially oppose them in the transition period where you have insurance reform along with existing policies that have not been updated. That could be a formula headed for disaster.

The requirement that each health plan conform to the provisions, within one year after the date of enactment of the Act, back to the date of enactment, is a logistical nightmare which will create a great deal of disruption and dissatisfaction with the policyholders who might be asked to pay more or receive a refund sometime later. Our experience in implementing community rates in New York as of April 1, 1993, which included refunds for payments beyond that date and billing of premium after that date, at a new rate level (higher and lower) will attest to these remarks.

Finally, the Transition rating rules apply only to insured individuals and groups and not to self-insured plans and HMOs. This could cause a serious imbalance and adverse selection between ERISA plans and the rest of the system during the Transition period.

I would suggest using rate reform similar to the rules prescribed in small group reform for that marketplace. For individual business, current state laws do not allow carriers to increase the premiums for specific individuals, due to their health experience, once the policy is issued. If there is concern over the relationship of different blocks of business, some sort of pooling approach could be devised which requires actuarial certification for

fairness without the complicated rigidity of this system. At the current time, it does not seem necessary to restrict the rating practices of large groups.

Portability (Limited Use of Preexisting Condition Limits)

Under the Clinton bill, group health plans (including ERISA plans) would be able to limit coverage for pre-existing conditions for up to six months during the transition period. Preexisting conditions involve conditions that have been diagnosed and treated within six months of the first date of coverage. These limits would not apply to newborns.

The preexisting condition limitation would be reduced for individuals previously covered under individual policies, group policies, Medicare or Medicaid, based on the amount of time they were previously covered. In other words, if a new employee previously was covered for six months, he or she would not be subject to a new preexisting condition limitation. If a new employee previously was covered for two months, he or she would still be subject to a preexisting condition limitation for a four month period. The previous coverage must have been continuous (with no more than three consecutive months without coverage).

Impact on Health Plans and Consumers

While we agree with this provision, it provides portability of coverage only to persons who are insured through group plans; no portability protection is afforded to individually insured persons who might want to change insurance carriers or health plans. We suggest applying the same approach for a portability provision for individually insured persons. This provision would permit a twelve month preexisting condition limit for persons newly insured with individual insurance, with credit for qualifying previous coverage, based on the number of months covered, as with the transition provision for employed persons. A twelve-month preexisting condition limit is warranted here because of the greater threat of adverse selection in the individual insurance market. This provision would improve the parity between individually insured persons and persons insured under group plans.

Reductions in Benefits

As of the effective date of the plan, self-insured plan sponsors may not reduce benefits for any medical condition or course of treatment, when the anticipated cost is likely to exceed \$5,000 in any twelve months.

Impact on Health Plans and Consumers

We assume this provision is to address situations, such as occurred with H & H Music, where a self-insured employer changed its benefit plan to exclude coverage for AIDS. We agree with this provision and believe it reflects good policy. As with guaranteed renewability, this provision reflects another transitional step to providing coverage that can never be taken away. It is instructive to point out that the over 20 million Americans currently covered by individual insurance policies cannot be singled out in this manner in

the current marketplace by having their policies cancelled or modified without the approval of the department of insurance.

High Risk Pool in the Clinton Plan

During the Transition period, the Federal Government will establish a national high risk pool. The purpose of the high risk pool will be to provide access to health insurance to persons unable to acquire private insurance because of their health status or condition.

The federal high risk program will build upon the state high risk programs; however, the federal government may administer the plan through contracts with:

- o one or more existing state health insurance risk pools;
- o one or more private health insurers; or
- o other contracts as appropriate.

The rules concerning eligibility, reimbursement of providers and premiums will be developed by the Secretary. All providers paid under this program will be paid at the Medicare rate.

Premiums will vary by age, place of residence and other traditional underwriting factors, other than on the basis of health status or claims experience. Premiums must equal, at a minimum, 150% of premiums charged to persons of average risk.

Benefits for the high risk pool will be comparable to those offered by state high risk insurance plans.

Short-falls in the pools, arising from claim costs that exceed premiums and expenses, will be funded via assessments on insurers and self-insured plans.

Impact on Health Plans and Consumers

The high risk pool represents an important effort to provide access to coverage for persons previously unable to acquire insurance. Some form of guaranteed access is an important hallmark for any effective transition plan.

The rule stating that premiums must be, at a minimum, 150% of the premiums charged to persons of average risk, will cause an increase in premium rates for current state high risk plan participants. This is in view of the fact that seven state high risk plans, including Nebraska's, limit this premium to 135% or less of the premiums of persons with average risk.

We have long supported state high risk pools, and as I mentioned, I personally serve on the Boards of three state high risk plans. This is the point, however, where the plan architects should ask themselves what type of system will get us to universal coverage and access in the quickest time-frame and with the least cost and confusion. At first glance, state high risk pools are appealing because they seem to work effectively, with 27 states currently operating

state high risk pools. However, you should be aware that one of the ongoing problems of state high risk pools is funding the shortfalls in the claims. In the Health Security Act, these shortfalls are funded by self-insured plans as well as insurance companies - this is a solution we can accept.

The remaining question is whether or not it makes sense to develop a new temporary structure and rules in at least 23 states when this structure will be dismantled in the reformed system anyway. Under the Health Security Act, state high risk pools won't exist after 1997.

Another way to ensure coverage for all persons (even uninsurable persons), before the mandate for coverage takes effect, is to implement limited guarantee issued coverage to individuals during an open enrollment period once per year and year-around guarantee-issue coverage in the small employer market. If certain individual and small group reform measures were instituted, instead of the Health Security Act Transition, the transition period would move toward the fully implemented reform goals at a quicker pace. Reform in these markets, along with the ERISA changes, would move reform along quicker and probably cheaper. Forty states already have enacted small group reform and they already are familiar with those rules.

Attached to this testimony is Appendix I, which discusses the individual insurance market and a proposal for reform in this area.

GOALS OF THE TRANSITION PERIOD

I believe the goals of a transition period are to move toward an environment of universal coverage by phasing in individual and employer mandates, and also by phasing in insurance reform rules to provide universal access and equalization of prices for insurance.

The Transition for insurance reform includes measures to bring about universal access. These measures include removing barriers to insurance, such as medical underwriting and preexisting condition exclusions and limits, disallowing termination of coverage and equalization of pricing. So why can't we do it all now - guarantee issue coverage year round, without any preexisting conditions and with community rating and other proposed reform measures?

The culmination of the Transition period is to achieve year round, guarantee issued coverage, no preexisting conditions for people moving around within the system, guaranteed renewability of coverage and some form of community rating, within an environment where everyone is covered by insurance. As long as the level of universal coverage, brought about via an individual and employer mandate, keeps pace with the insurance reforms, the transition and resulting fully implemented reform can be successful.

If full insurance reforms are implemented either before or in the absence of universal coverage, serious consequences to insurers and consumers will result. This is what happened to the individual insurance market in the State of New York, which functions as Mutual of Omaha's laboratory of insurance reform. As I will describe, my statements regarding the impact of insurance reforms without universal coverage are based on true life experience and data.

Full Insurance Reform Before or Without Universal Coverage - The New York Story

In 1993, the State of New York instituted legislation requiring insurers to:

- o Provide health insurance coverage to individuals and small employers who apply regardless of health status (i.e., guarantee issue); and,
- o Charge all persons the same premium for health insurance, regardless of their health status, age, etc. (i.e., pure community rating).

The following describes the impact this legislation had on Mutual of Omaha individual policyholders within the first nine months of implementation.

Impact of Pure Community Rating on In-force Premiums in New York:

The most notable result of pure community rating was the increase in premiums for the majority of insured persons. When pure community rating was instituted, premiums increased for about 60% of individually insured persons. Thirty percent of insured persons experienced premium increases of 20% or more.

SUMMARY OF CHANGES IN RATES UNDER COMMUNITY RATING IN NEW YORK FOR INDIVIDUAL HEALTH INSURANCE

PERCENT WHO INCREASED	PERCENTAGE CHANGE	PERCENT WHO DECREASED
9.0%	0% to 5%	6.3%
20.7%	6% to 19%	14.9%
17.8%	20% to 39%	15.8%
11.3%	40% to 59%	3.2%
0.9%	60% to 79%	0.1%
59.7%	Totals	40.3%

* Total number of units of coverage (male, female and family coverage) equal 15,708. Total percentages on increases and decreases equal 100%.

We recently received a letter (dated January 3, 1994) from a 29 year-old male policyholder from New York who was writing to cancel his coverage because of a premium increase. "I

am now without any health insurance whatever. My only recourse is to do what I've done - stay healthy [and] hope for continued luck..." (Policyholder Letter 1-3-94). We, along with many legislators, have received letters like this voicing anger about the new law.

In a report submitted to the New York legislature by the New York Department of Insurance, it was reported that as a result of pure community rating a single male age 30 received a 170 percent rate increase and a family of four, with the principal insured age 30, received a 90 percent rate increase.

Impact on the Number of Insured Persons:

The goal of the New York legislation was to increase access to coverage and hence the number of insured persons in New York. Unfortunately, the regulations have caused the number of insured persons, based on our experience, to decrease. Because individuals are not required to purchase coverage, many persons insured with Mutual of Omaha chose to drop their coverage. Other persons decided not to purchase coverage. Because coverage is guaranteed issue, by law, persons know they can wait outside the system and then acquire health coverage after they need it.

The number of Mutual of Omaha individual insurance policies dropped by over 30 percent within the first nine months of the new New York system.

What Happened to Persons who let their Mutual of Omaha Coverage Lapse?

In a random survey of New York residents who were formerly insured by Mutual of Omaha:

- o 58% of persons surveyed lapsed their coverage because of cost;
- o of those who lapsed coverage, 55% purchased other health insurance, while 43% went without insurance coverage - and hence were uninsured;
- o of those persons going without coverage:
 - 51% were between the ages of 26 and 35
 - 21% were between the ages of 36 and 45;
- o of the 55% of persons who purchased coverage from another carrier, 78% of these purchased catastrophic-type plans;
- o of the 55% who purchased coverage from another carrier, 40% acquired coverage through an employer-sponsored plan.

Our New York experience is an example of the great potential for adverse selection in an environment of voluntary coverage with full insurance reform. They got the cart before the horse. Pure community rating pushes premium prices above the perceived value of insurance for low risk persons. Without a mandate to purchase insurance, those persons with low risk will drop coverage, based on rational economic decision-making. With guaranteed issue and community rating, they can wait until they get sick to buy insurance. Although plans in New York have a twelve-month preexisting condition limit, persons without insurance may not know or understand what this means to them until it is too late. For some younger, healthier persons, this is a calculated risk they are willing to accept. Although a risk adjuster is part of the New York system, it still cannot compensate for the

overwhelming loss of low-risk individuals. As a result, premiums rise for those persons left in the pools, driving more low risk persons out, and on and on. Unfortunately, when they eventually need insurance the price will probably be too high to bear.

Make no mistake, we are not suggesting that Congress forego insurance reform, only that insurance reforms must occur lock-step with universal coverage. If not, certain important modifications must be made to the reform proposals under consideration in order to protect the stability and solvency of the marketplace. These modifications will mean that persons will not have access to insurance at their convenience or whim. Protection of the pools can be accomplished by preventing persons from waiting until they need insurance before entering the pool. We believe this is fair and equitable to those who undertake the responsibility of insuring themselves against risk, and will encourage more people to voluntarily join the pool, thereby keeping prices at a more affordable level for everyone. Our experience in New York truly speaks to the equity of mandated coverage in a reformed marketplace.

ALTERNATIVE REFORM AND TRANSITION SCENARIOS

Insurance Reform without a Mandate for Coverage - What Can Be Done?

In reality, there is a distinct possibility that an employer and individual mandate will be phased in over a long period of time, or that no mandate will be realized at all. Full universal insurance reform without a mandate, is harmful to consumers, in that persons outside of the insurance system can benefit at the expense of those persons inside the system (who have faithfully paid premiums for years). It is not an insurance company issue as much as it is a consumer issue. Hence, under a scenario of voluntary coverage, we would recommend only the following insurance reform measures. These measures specifically address the individual market. In addition, we continue our support for small group reform:

1. Preexisting condition exclusions should apply, only for "first-time" buyers of insurance or those with a long lapse period since they were previously covered. This would limit the ability of persons to wait until they are sick to get insurance, while rewarding those who take personal responsibility.
2. Open enrollment should occur once per year at the same time for all individual carriers. This reduces the ability of uninsured persons to wait until they become sick to join. Under these reforms, access for persons wanting to purchase insurance will not be limited as long as they purchase insurance during the appointed open enrollment periods and remain insured. This method imposes a responsibility on persons who do not purchase insurance, without imposing a requirement for them to be insured. Again, from an equitable standpoint, each individual should bear some personal responsibility for choosing to remain outside the system.

3. Medical underwriting should apply to persons who want to join outside the open enrollment season. Underwriting these persons protects individuals who purchased insurance during the open enrollment period. Persons previously covered who leave their job and are terminated under their plans would be automatically eligible for another insurance plan regardless of the open enrollment period, without satisfying a new preexisting condition period.
4. Modified community rating should be imposed rather than pure community rating. Modified community rating prices premiums commensurate with an individual's relative risk for service. We are not suggesting that premiums be based on health status, rather one's statistical risk should be based on specific, objective characteristics. This would make it less costly for young or healthy people to stay in the pool, since their rates would typically be lower. This could avoid a sense of inter-generational inequity by younger Americans caused by pure community rating since the disposable income for older Americans generally exceeds that of younger Americans.

Modified community rating means that claim costs, i.e., health experience, are evenly distributed across all of a carrier's policyholders. Premiums are then modified for individuals and groups to reflect demographic and other factors that predict health care use. For a competitive, stable marketplace, premium rating factors should reflect certain underlying assumptions:

- o Rates should be perceived as economically fair by most sectors of society; and
- o Rate differentials should not be imposed for random, uncontrollable conditions, such as brain tumors.

The concept of pure community rating does not support these underlying assumptions, as demonstrated by our New York experience. To provide health care premiums that reflect equitable value, we recommend using, at a minimum, certain factors in pricing premiums, such as: geographic area, age, family composition and wellness factors.

Insurance Reform with a Mandate for Coverage - The Best Case Scenario for Everyone

Mandated coverage ensures that individuals cannot time their decisions to acquire insurance coverage based on their health needs, and thus select against other insured persons. Mandates also protect the premiums of those with insurance and reduce the need for preexisting condition exclusions and other limitations in coverage.

Under universal coverage we suggest the following modifications to insurance reforms:

1. A one-time, front-end preexisting condition limitation only for those entering the system for the first time, or for those who violate the mandate.
2. Modified community rating to ensure that the economic value is commensurate with the price as discussed earlier in this testimony. This will increase the level of compliance

with the mandate by younger and healthier citizens.

3. Guaranteed issue, year around, for a standard benefit package. This coverage also would be guaranteed renewable (except for insurers exiting the market, as is the case today in the individual insurance market). Carriers would not be permitted to cancel coverage based on claims history or health experience.
4. Underwriting would be permitted only for supplemental benefits. Supplemental benefits would be rated separately and acceptance of applicants could not be tied to coverage for the standard benefits package.
5. As we have discussed, these reforms should occur only in lock-step with the mandate for coverage.
6. Insurers should be given authority to substitute new standard policies for old policies. This will ensure a standard level of coverage for all persons without duplication.
7. Insurers must be able to exit sectors of the market or to sell or cancel blocks of business. Insured persons would be protected and able to acquire insurance without preexisting conditions and guaranteed coverage from other carriers.

The New York experience notwithstanding, some level of insurance reform is possible with or without a mandate. To achieve full reform, all persons must be included in the system. To neglect a mandate is to fall short of universal coverage and access. To require full access to insurance without a mandate is to ensure that the system will collapse within time and all insurance will be handled by the government because no private carriers will be left.

CONCLUSION

Based on our review of the Health Security Act, we have observed serious flaws in the Transition Section, regardless of the final reform measure. These include the immediacy of the transition rules, as well as the complexity and severity of the rating restrictions.

More than that, we believe there is a better way to accomplish the transition objectives, which are to provide stability and equity of insurance premiums; improve access to insurance, regardless of health or employment status; and encourage movement toward universal coverage. Varying degrees of individual and small group reform should be implemented, depending on the presence or progression of universal coverage. This will accomplish the goals of the transition, and possibly the new market. The lessons learned in New York will serve us well if we apply them to future reform.

If nothing else, I hope that our testimony illustrates that immediate implementation of the transitional provisions included in the Health Security Act would have a negative and harmful impact on consumers and on the stability of the insurance marketplace. It is

paramount that any transition to a reformed marketplace occur in a logical and careful manner without jeopardizing the stability of coverage that currently protects an overwhelming majority of the American population. We believe our testimony has not only outlined the problems that should be considered in reforming the insurance marketplace, but provides solutions as well. Thank you.

APPENDIX I
REFORM OF THE INDIVIDUAL INSURANCE MARKET
JANUARY 26, 1994

Three categories of insurance exist in today's health market: large group, small group and non-employer related individual insurance coverage. Large group insurance provides coverage under one contract to a number of persons who have a specific relationship to the policyholder. These group plans use experience rating, in that, the group's rate is based largely on the demographic characteristics and utilization experience of that particular group. Small group insurance is found in the continuum between individual and large group. While there is no industry standard for large or small employers, our small group clients generally have between three and fifty eligible employees.

On the opposite end of the spectrum from large group insurance, is individual insurance. A total of 22 million persons (roughly 9% of all citizens) are covered by non-employer related individual health insurance. This coverage is provided by commercial insurance companies, Blue Cross Blue Shield Associations and Health Maintenance Organizations (HMOs).

THE INDIVIDUAL INSURANCE MARKET IS UNIQUE

What is Individual Health Insurance?

As with group health plans, major medical individual insurance provides comprehensive hospital and medical coverage. Coverage for inpatient services includes a variety of facilities including hospitals, skilled nursing, home health and hospice care settings. Outpatient medical coverage typically includes benefits such as physician office visits, outpatient surgery, ambulance services and prescription drugs.

Benefits are paid based on a cost sharing arrangement which includes a calendar year deductible and coinsurance amounts. The insured's financial exposure is protected by an out-of-pocket maximum; covered expenses beyond the out-of-pocket maximum are paid up to a defined amount per insured person.

How is it rated?

Group insurance typically is priced based solely on the coverage type (employee-only or family) and plan option selected. These prices reflect a composite of the characteristics of all insured employees. Individual health insurance premiums are based on several specific characteristics of the buyer:

- a. Plan option chosen, e.g., deductible and coinsurance selected
- b. Age
- c. Gender
- d. Geographic location
- e. Wellness factors, e.g., tobacco use

Premiums are determined by the evolving experience of all policyholders having coverage under the same form in a geographic location. Premiums may increase each year due to:

- a. Change in age of the policyholder
- b. Experience of the block and increasing medical costs
- c. A move by the insured person to a new geographic location

Rate adjustments may be made only when the same change is made on all similar policies issued to persons living in the same geographic area of a state. An individual person may not be singled out for a rate adjustment based on their individual claims history.

Individual Insurance is Highly Regulated

Unlike group insurance, individual insurance is highly regulated by the states, which require policies to be filed with each state's insurance department before the product can be sold in that state. State approval includes both policy benefits and, in most states, rate filing requirements. Since each state's regulations and state-mandated benefits may differ, product design and pricing vary greatly from state to state.

A common misconception is that individual insurance companies single out insured persons and cancel their coverage when they experience high claims. By contractual provision, cancellation (or non-renewal) can occur only if similar action is taken with all policies of the same form. Individuals may not be canceled because of their own poor claims history.

Managed Care and Individual Health Insurance

There is a common perception that managed care tools are applicable only to group health coverage. Several managed care techniques are used to help contain costs and assure quality and appropriate care for individual health insurance policyholders. These techniques include:

- o **Pre-certification of Hospital Confinement**
To assist patients in assuring appropriate and necessary care treatment, hospital admissions are pre-approved as medically necessary. This helps ensure full payment of benefits by Mutual of Omaha. Emergency admissions are reviewed as soon as possible after the admission. This prevents inappropriate hospitalization for unnecessary procedures or for procedures which can be performed on an outpatient basis.
- o **Utilization Review, Concurrent Review or Retrospective Review**
Utilization review is a means to oversee inpatient and outpatient services to ensure they are medically necessary and appropriate, based on standard practice guidelines. Performed by health care professionals, this is comprised of several processes including: application of practice guidelines, continued-stay review (concurrent review), discharge planning and second surgical opinion.

Concurrent review specifically pertains to the ongoing review of a patient's condition and need for continued hospitalization during hospital confinement. Retrospective review establishes a profile for inappropriate care for monitoring practice patterns and addressing excessive use or costs.

o **Case Management**

Case Management is a written alternative treatment plan endorsed by the insured person's physician and insurer to provide medically necessary and appropriate care in a cost-effective setting. A team of health care professionals work with the patient, physician and family members to give seriously ill patients the right care at a hospital or at home. It is typically used with catastrophic injuries or sickness, e.g., burns, chronic liver disease, amputations, organ transplants and spinal cord injuries. Participation in the plan is optional. This program allows patients to maximize benefits fitting their singular situation.

o **Centers of Excellence**

Mutual of Omaha selects qualified facilities that specialize in complex medical treatment. These facilities are chosen because they do more procedures with better results than others. Mutual of Omaha's centers are regionally located throughout the United States and are chosen for their leadership role in performing high quality tertiary procedures, such as transplants. An insured person who needs tertiary service is encouraged to utilize these facilities. Costs (for both the insured and the insurer) are managed based on a preferred provider arrangement. In addition, transportation costs for the insured and family member to the tertiary facility may also be included.

o **The Reversal Program**

Mutual of Omaha is the first insurance carrier to cover services associated with an innovative program to reverse severe coronary heart disease through a vegetarian diet, exercise and changes in lifestyle. It is expected that this program will substitute for surgery, angioplasty and other therapies for some patients, potentially staving off some of the billions of dollars spent on America's leading health problem - heart disease. Participants fitting certain criteria, such as the need for an angioplasty, may choose to participate in this program. As part of the pilot, the participating providers will count the cost of the Reversal Program toward the cost of an angiography, if the procedure is still required, despite participation in the program.

Other Unique Features of Individual Insurance

o **Individual Insurance is Portable**

Individual insurance is issued to qualified individuals regardless of employer affiliation. In contrast to group health insurance, it is completely portable and assures continuous coverage regardless of the insured person's employment status and medical condition.

o **Individual Policies May not be Canceled Due to Medical Conditions**

Individual policies are not individually experience rated, but are rated, at a minimum, by policy form grouping, if not in larger groupings. In other words, an individual's health status or claims experience does not have a direct bearing on rate increases. In addition, carriers are not allowed to single out an individual policyholder or cancel their coverage or raise rates because of poor claims history. All policyholders of the same form must be treated similarly.

Agents Bring Value to the Product

Mutual of Omaha sells individual health insurance through our career agency force. These 3,300 personal agents assist their clients in understanding and choosing the best benefits and financial planning products. Our agents are specially trained to analyze the needs of their clients and to pair those needs with appropriate health benefits, and other health and financial products. The role of personal agents is to assist persons in assessing needs and purchasing insurance. This is particularly crucial in rural areas where consumers have traditionally relied upon agents to assist them. (As you are aware, in largely rural areas, it is not uncommon for an agent to drive 100 miles, to assist a family with a claim form or to deliver a new policy.)

Personal agents follow specific enrollment criteria and guidelines established by the company. The agent's personal goal is to insure all persons within their sales perimeter. This provides for an inherent balance between the insurer, who must manage risks to survive in the current voluntary environment and the agent, whose goal is to insure everyone. Mutual of Omaha agents provide an important service to persons, particularly those residing in small towns and rural areas. Per capita, Mutual of Omaha sales are the highest in small towns and rural areas, where fewer persons are able to participate in employer-sponsored health plans. We have shown ongoing commitment to farmers and ranchers who depend on us for health insurance coverage.

PROBLEMS WITH THE INDIVIDUAL MARKET

Why is Individual Insurance Reform Necessary?

Some of the weaknesses of the current health care system, such as access and rising cost spirals, point to the need for reform in the Individual Health Insurance market and requirements for all citizens to acquire coverage. Historically, in the absence of a universal mandate for insurance coverage, major reforms were not feasible. Healthy persons often opt out of the market because of price, causing the experience to deteriorate for those left in the pools. Because of the opportunities for younger, healthier consumers to obtain coverage for a lower price, insurers, to keep coverage affordable, would retire certain pools and offer fresh new rates to qualified applicants. Thus, the older the pool, the worse the experience and higher the price.

Individual health insurance premiums are based on several risk factors as already discussed. Financial access to individual health policies may be greatly increased if the insured is willing to share a greater portion of the risk for smaller medical bills.

Nevertheless, the so-called "death spiral" for some individual health insurance is real. As long as healthy individuals are able to opt out of insurance pools in favor of a lower price, or choose to be uninsured, persons forced to remain in their original pool will face higher and higher benefit costs and premiums. Insured persons are essentially trapped; even many state high risk pools will not allow these persons to purchase coverage since they already have "access" to insurance. Rate increases are needed to pay for claims by the other members of the pool. The answer is to require all persons to acquire insurance coverage and provide a modified community rate, based on at a minimum geographic location, age, family composition and wellness factors, such as smoking. This assures a more uniform spread of health experience.

Individual insurance reform, coupled with a mandate to purchase coverage, will help solve this predicament. Everyone will have coverage and rating will be based on a level field of broad experience. Regardless of other health care reform measures (Health Alliances, Accountable Health Plans) individual and small group reform will provide the underpinnings for universal access and coverage.

Costs of Individual Health Insurance

Individual health insurance is the last stopping point for cost shifting. All un-recovered costs resulting from uncompensated patients, patients covered under Medicaid, Medicare or even group plans receiving deep discounts, are shifted to individual insurance plans. Individual insurance plans historically did not have sufficient buying power in any region to acquire preferred provider discounts - hence the cost increases for individual insurance are the highest in the industry. It is estimated that private individual health insurance pays hospitals 30% more than the cost, to compensate for the under-payment by other payers.

The Role for Individual Insurance in a Reformed Health Care System

Individual insurance will continue to meet insurance needs not met by employers, particularly for persons in rural areas and small towns. It also may serve as an important vehicle to transition individuals into a reformed insurance environment. If radical reform is implemented, individual insurance will play an important transition role to move citizens into a new structure. If moderate reform is implemented, individual reform could play a key role in servicing citizens, especially in small towns and rural areas as part of the plan.

PROPOSAL FOR INDIVIDUAL HEALTH INSURANCE REFORM

Introduction

Fundamental change to the individual health insurance structure is a prerequisite to providing universal security and any hope of controlling costs. To achieve this change it is imperative to recognize and build on the value each participant brings to health care. The following outlines Mutual of Omaha Companies' view of our role and responsibility in health care reform.

Mandated Environment

To achieve universal coverage that is guaranteed issue and guaranteed renewable, all Americans must purchase insurance coverage for a standard benefit. The government also must provide subsidies, based on ability to pay, to persons unable to afford this coverage. Without such a mandate, it would be possible for individuals to wait until coverage is needed before purchasing it. This would engender an environment of adverse selection, driving up costs for insured persons.

Guarantee Issue Within a Mandated Environment

In a mandated environment, all insurers would be required to provide **guaranteed** coverage regardless of health status. This means a person with AIDs would receive health insurance as readily as a healthy person. (If a higher percentage of persons with poor health enter certain plans, these plans would participate in reinsurance arrangements or receive risk adjusters to compensate for the adverse experience and higher claims costs.) The ability to accomplish this is entirely dependent on universal coverage, as a result of mandated coverage, and the use of a valid risk adjuster.

Continuity of Coverage for Insured Persons

If a person loses his or her job, or moves to another state, their access to insurance coverage remains intact. (If an insurance company can not meet its obligations, it would be forced to cancel all persons covered. These carriers should be barred from selling health insurance in that state for a period of five years. Persons losing coverage as a result would go to another carrier and receive guaranteed coverage.)

Rating Requirements

As discussed, premiums would be based, at a minimum, on specific characteristics, such as geography, age, wellness factors (such as smoking) and family composition. The health experience of all persons fitting these characteristics then will be accumulated for each characteristic. Because all persons are included under universal coverage, rating should be equalized across all persons within a characteristic.

Pre-existing Conditions

Universal "cradle to grave" coverage, mandated individual coverage and guarantee issue of coverage would make the use of pre-existing condition clauses moot. However, during the transition and for those individuals that violate the mandate, pre-existing condition provisions are necessary to guard against adverse selection.

Supplemental Coverage

Insurance companies would be allowed to sell supplemental coverage to consumers. Coverage purchased in addition to the Standard Benefit Package would be underwritten and sold as a separate rider or supplemental policy and regulated separately.

Other Reforms

All providers would be required to charge consistent fees to their patients. Certain patients and payers should not receive special discounts unless true savings can be demonstrated. In addition, the government should pay its rightful share of costs, particularly before assuming the additional liability of expanded health care coverage.

Individuals and employers should have the option to purchase insurance coverage from several market sources including purchasing pools, or directly from insurance companies or through agents or brokers.

Insurance companies and health care providers should have the freedom to provide several forms of health coverage, such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) or "free choice" indemnity plans.

Medical malpractice reforms must be instituted to reduce the practice of defensive medicine and encourage alternatives and boundaries to litigation, settlements and punitive damages.

Mrs. COLLINS. Ms. Fox.

STATEMENT OF ALISSA T. FOX

Ms. FOX. Thank you, Madam Chairwoman and members of the subcommittee. I am Alissa Fox of Blue Cross and Blue Shield Association. Blue Cross and Blue Shield plans provide coverage to 68 million people. Over $\frac{1}{3}$ of our enrollment is in managed-care networks.

The Blue Cross and Blue Shield Association strongly supports the President's objectives for health care reform; health care coverage for everyone, strict new standards for insurers, and cost containment through managed-care networks. We want to see a bill enacted this year. We believe that insurance market reform is the fundamental building block for the goals of universal coverage and cost containment.

I cannot overemphasize the significant impact of insurance reform. Right now insurers are competing on risk selection, trying to identify healthy groups and offering them coverage and excluding the sick. These practices need to stop. Once these practices are ended, health plans will have no choice but to compete on their ability to manage costs and provide high quality care.

Specifically, we support reforms that would require health plans to take all comers regardless of their health condition, charge fair premiums, and not penalize people because they are sick or older. We support community rating, up to group size 100, ban preexisting medical conditions once everyone is covered, and assure that once you have coverage, it can't be taken away.

These are fundamental changes. They will require health plans to develop new ways of doing business. It is very important that the transition period move steadily and swiftly, but in an orderly way to a restructured health care delivery system. We have serious concerns with the transition rules included in the President's plan. We believe the transition period should get you to where you want to go. However, the transition rules in the President's plan essentially place health plans in a holding pattern at a time when they should have the flexibility to move to reform goals.

It freezes the current system in place. Then on day one of the new era, all the old arrangements are to be swept aside and replaced by the new arrangements. This is a prescription for massive problems, not a road map for getting to where we want the health care system to go.

In my written testimony, I have identified five provisions that are especially problematic. These include, first, the establishment of national high risk pool, which would be totally unnecessary if health plans were right away told to take everybody.

Second, the requirement for limits on premiums during the transition are problematic, especially when there are no uniform standards or no uniform benefit packages.

Third, the requirement that premium rate increases apply across all segments of the market disadvantages health plans like ours who offer coverage in all three segments. Most companies don't. Moreover, this requirement would give incentives to employers to self-insure to avoid resulting rate increases.

We believe in an alternative approach to the proposed transition is needed. We believe certain provisions should be implemented immediately. These include, first, guarantee issue, tell health plans open their doors right away. Under the President's plan, this wouldn't happen until the alliances are constructed and that would happen several years later.

Second, immediately upon enactment all health plans should be prohibited from canceling coverage and preexisting condition waiting periods should be limited. Third, health plans should be required to maintain their current level of benefits and be required to report information needed for reform. We believe a transition period is needed to move to community rating to limit rate increases for individuals and small groups, and that way you wouldn't have the problems that we just heard in New York, if you move to community rating and not do it all at once the way the President's plan proposes.

A transition period is also necessary to allow health plans sufficient time to develop standardized benefit packages and to adjust their rates accordingly.

In closing, we believe a transition period that is designed to smooth the way to the new system while assuring consumer protection is essential. We want to work with your committee in designing an effective transition. Thank you very much.

[The prepared statement of Ms. Fox follows:]

**TESTIMONY OF
BLUE CROSS AND BLUE SHIELD ASSOCIATION**

PRESENTED BY

**ALISSA FOX
EXECUTIVE DIRECTOR
OF CONGRESSIONAL RELATIONS**

Madam Chair and members of the subcommittee, I am Alissa Fox, Executive Director of Congressional Relations of the Blue Cross and Blue Shield Association, the coordinating organization for the 69 independent Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefits protection for about 68 million Americans. I appreciate the opportunity to present our views to you on the transition provisions in the Health Security Act.

Transition period is key to successful health care reform

The Blue Cross and Blue Shield Association supports universal coverage and a cost containment strategy that relies on competition among Accountable Health Plans based on price, quality and service. We believe that insurance market reform -- strict federal standards for Accountable Health Plans -- is the fundamental building block for the goals of universal coverage and cost containment. These reforms will establish a new standard of accountability for health plans and providers. They will put an end to competition based on the ability of a health plan to avoid covering people with serious medical conditions. They will require health plans to compete on the basis of their ability to manage costs. After reform:

- Everyone would be able to obtain coverage regardless of their age, health status or employment status;
- Individuals would receive fair premiums and not be penalized because they are sick or older;
- No one would have their coverage limited to exclude 'pre-existing' medical conditions and no one would be dropped when they get sick; and

- Consumers would be able to select their health plan based on a careful and informed weighing of cost and quality.

These are fundamental changes. They will not occur overnight. They will require health plans to develop new ways of doing business. It is critical that the transition period move steadily and swiftly, but in an orderly way, to a restructured health care delivery system.

A smooth, orderly transition is critical to maintain public support for reform. The public will not be happy if the design of the products they select change significantly from year to year, or if the health plans they select are forced out of business. Moreover, if health plans do not have the flexibility to spread over time the rate increase required by community rating, some people may experience premium shock.

Health plans need the transition period to restructure

The changes that reform will bring about present an enormous challenge for health plans. The Health Security Act would change virtually every incentive that shapes decisions by health plans, consumers and providers. Health plans must address the following issues during the transition period:

1. Health plans will have to modify their benefit design to comply with the requirement for a standard benefit product and to adjust their premium to reflect the new benefit level. To implement these changes health plans will have to educate consumers, develop a new rate structure, and obtain any necessary regulatory approvals.

2. Health plans will need time to phase in community rating for those segments of the market that are covered under a community rating requirement. As the use of experience rating is phased out, some groups will receive premium rate increases and others will receive decreases. Health Plans need a reasonable amount of time to 'spread' the changes in premiums so that groups and individuals can absorb the shock of premium rate increases.
3. Because health plans will be competing directly on the basis of their ability to manage costs, and not on the basis of benefit design or risk selection, they will need to develop and implement new strategies to manage costs. These strategies will include products that rely on tighter networks of providers, new risk-sharing arrangements with providers, and new techniques to manage utilization. To implement these changes, health plans will need to renegotiate contracts with providers and educate current subscribers.
4. A health plan will have to anticipate how consumer behavior will change as a result of changes in both the products it offers and the number and types of products offered by competitors. It will be particularly difficult to predict consumer behavior if reform expands the ability of individuals to select their own health plan. Moreover, health plans will have to anticipate how consumers will behave in a market with strict new rules that change options that are available (e.g., standardized benefits, guaranteed issue, community rating requirements, and requirements to offer coverage in all market segments), and that includes both new competitors and established competitors who are bringing their own new products to the market.

5. The state will need time to develop and test a potential risk adjustment mechanism. Prior to using a risk adjuster, the state will need to gain experience with a risk adjuster and determine the impact on premiums. And health plans will need to evaluate the impact that risk adjustment will have on their premiums.

Transition rules in the Health Security Act

The Health Security Act (HSA) transition provisions place health plans in a holding pattern at a time when they should have the flexibility to move to reform goals. It freezes the current system in place. Then, on day one of the new era, all the old arrangements are to be swept aside and replaced by the new, and entirely untested, arrangements. The intention of these provisions is to prevent health plans from 'gaming' the system in an effort to secure a more competitive position in the market. However, the proposed rules are a prescription for chaos -- not a road map for getting from where the health care system is today to where we want the health care system to be tomorrow.

We have identified five requirements in the transition rules proposed by the Health Security Act that preclude the flexibility that is needed to ensure a smooth orderly transition to a reformed health insurance market.

The Health Security Act would require health plans to obtain prior approval from their state regulators if their annual premium increase exceeded a percentage specified by the Secretary.

The intent of this provision is to preclude health plans from increasing their rates for groups or individuals with above average claims experience. A more effective alternative would be to require a rapid phase-in of community rating within narrow bands for the small group market (employers with less than 100 employees). Separate rates (i.e., separate pooling of claims experience) for individuals and groups should be allowed until universal coverage is achieved.

The Health Security Act would require health plans to apply equal premium rate increases for all plans in all three markets -- individual, small and large group.

This provision could adversely affect those health plans that currently offer coverage in all three markets. Health plans that have offered coverage in all market segments, from individuals through large groups, are likely to have experienced adverse selection. Requiring health plans to increase rates by the same amount in all market segments could require health plans to subsidize losses incurred in some segments by raising rates in other segments. This cross-subsidization would jeopardize the ability of the health plan to remain competitive in all market segments.

Furthermore, it would preclude a smooth transition to a community rating requirement that pools individual, small group and some participation of larger group claims experience. Under such a requirement, health plans will need the flexibility to make a major redistribution of claims costs across market segments.

Finally, it is unclear how or if this requirement would be applied to health plans that are introducing new products. Health plans should be allowed to vary their annual premium rate increases across the individual, small and large group markets.

In the Health Security Act, health plans would be required to accept new employees of an employer group health insurance plan, but would not be required to cover new employer groups.

We believe it is essential that health plans offering coverage in the small group market guarantee issue coverage to all groups. In the absence of such a requirement, health plans that have benefited from risk selection will be able to preserve their competitive advantage through the transition period. Until universal coverage is achieved, health plans should be allowed to impose minimum participation requirements.

The Health Security Act would establish a national transitional health insurance risk pool to provide coverage to individuals who are unable to secure health insurance coverage from private health insurers because of their health status.

We do not believe that the national high risk pool would alleviate the uneven distribution of risk existing in the market. The pool would not be available to currently insured high risks, so they would remain with their current health plan. In addition, we do not believe it would be realistic to develop a major new federal program that would operate only for a few years. Moreover, such a program would require major subsidies because of the poor risk selection such a program would experience. A better solution would be to require all health plans to accept all applicants within a relatively short period after enactment. This would ensure that all groups and individuals have access to their choice of private health plans, and would move the private market in a direction consistent with longer term reform. In addition, many states already have risk pools for uninsurable individuals.

In the Health Security Act, the Secretaries of Health and Human Services and Labor would have dual responsibility for regulating health plans.

The Secretary of Health and Human Services should have primary oversight of the regulation of health plans. We believe, however, that the states should have the day-to-day responsibility for regulating health plans. To ensure a level playing field, we would argue that health plans should be regulated by a single entity within each state and be subject to the same federal standards. Dual regulation also could result in uneven regulation of health plans.

Alternative transition rules

We believe an alternative approach to the proposed transition is needed to avoid unnecessary uncertainty, to allow health plans and providers to concentrate on the redesign of their health care delivery and financing arrangements and to implement the new standardized benefit packages. Health plans need the transition period for the following activities:

- Development of organized delivery systems. A significant period of time will be needed for health plans to develop organized delivery systems in order to be competitive or reorganize their existing delivery systems.
- Development of standardized benefit packages. A significant period of time will be needed to modify all existing benefit packages, educate consumers and providers, re-rate the products and redesign all marketing and explanatory materials.

- Move to community rating. Health plans should be allowed a reasonable period of time to phase-in community rating with narrow demographic bands in the small group and individual markets. During the transition period to universal coverage, health plans should be allowed to set separate community rates for individuals and small groups.

While a transition period is necessary to implement some provisions of reform, we believe certain other provisions should have a relatively short implementation period:

- Guaranteed issue. Within a relative short time after enactment, health plans should be required to offer their small group coverage on a guaranteed issue basis, that is, without regard to health status or claims experience. Within a somewhat longer period, all health plans should be required to offer their individual coverage on a guaranteed issue basis. It is important to recognize that guaranteed issue requires the enactment of reform that will result in universal coverage. In the absence of such requirements, over time, risk selection will be more difficult to control.
- Guaranteed renewal. Immediately upon enactment, all health plans should be prohibited from canceling coverage for reasons related to an individual's or group's health status or claims experience.
- Limits on pre-existing condition waiting periods. Immediately upon enactment, all health plans should be limited in their ability to impose pre-existing condition waiting periods on new subscribers. These waiting periods should be limited to 6 months for conditions existing in the previous 6 months.

- **Information.** Immediately upon enactment, all health plans should be required to report information needed by the states to monitor costs, implement comprehensive reform, and develop a risk adjuster.
- **Benefit package.** Immediately upon enactment, all health plans should be required to maintain their current level of benefits. Health plans should have an adequate period to develop the capability to offer the standardized benefit packages.

Conclusion

I would like to reiterate our strong belief that flexibility during the transition period is key to successful health care reform. The transition should provide health plans with the opportunity to restructure their products and the way they do business so they can compete effectively once reforms are fully implemented. The transition also should buffer employers and families from the sudden shock that immediate implementation of reform would cause.

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Mrs. COLLINS. Thank you. Ms. Fox, how long do you think the transition period should be?

Ms. FOX. We believe that the transition period should transition for different things. We believe certain things should happen right away. The guarantee issue should happen right away, limits on preexisting condition, community rating probably takes a couple of years, 2, 3 years before you get there as a way of limiting premium increases that could cause people to drop their coverage. So we think that there should be a schedule and look at different provisions.

We don't think that you need to wait for alliances to be constructed before you get to universal coverage and cost containment. We think you should start on that path right away, get people covered, providing subsidies for that coverage and getting costs under control.

Mrs. COLLINS. I notice that in your statement you didn't include too much of a discussion about solvency regulations during the transition. Is it your understanding that the State, in your opinion, commissioners are going to continue to regulate health insurers for solvency during these various transition periods?

Ms. FOX. That is my understanding.

Mrs. COLLINS. Do you think there is a problem with separating the regulation of premium rates from the regulation of solvency?

Ms. FOX. Oh, definitely.

Mrs. COLLINS. If there is, what can we do about it?

Ms. FOX. I think that is a definite problem. We think the State insurance commissioner should continue to regulate solvency. That continues to be an important step. That is why we have lots of concerns with premium caps, it is just that there has—you are capping the premiums, and you really need to look at the solvency concerns and lots of other things.

The problem with the President's program is that he has everything happening all at once. He has new benefit packages, he has people being covered. There is just a whole series of things that he is proposing to happen all at the same time, making setting of premiums very problematic. There have been a number of papers that have just been written just this week on these issues that highlight how difficult it is for any health plan to estimate those premiums, given all those changes happening at the same time, and, therefore, we would propose that you have a more even transition to the new system.

Mrs. COLLINS. Do you agree with that, Mr. Bykerk?

Mr. BYKERK. I certainly agree that we need a more even transition and a gradual transition. With respect to the regulation of solvency and premium rates, we do think there is a tie there. And it is very important to keep some oversight over both elements of that.

Mrs. COLLINS. The transition rules include certain conditions under which a health insurer can cancel coverage, Mr. Bykerk. Should this title also allow, do you think, for cancellation of a policy if the policyholder moves to a State in which the insurer is not licensed?

Mr. BYKERK. Currently, most policies would—if it is a fee-for-service individual policy, I will look at that for the moment. If a

person moves to a State the insurance company is not licensed in, they can—you know, they can keep their coverage. They are not canceled.

Now, if you get into group coverage, you can get into some problematic situations if they are using some kind of a network where the network isn't there. That does create some problems. But as far as generally speaking, I don't see any reason that they should be forced or allowed to cancel someone just because they move jurisdictions.

Mrs. COLLINS. What do you think about companies probably wanting to exit the market, Mr. Bykerk, during the transition period? Do you think some might? And if so, why would they want to do so?

Mr. BYKERK. Well, in the course of business in any year, whether it is transition or otherwise, there are companies that drop out of the marketplace, that decide that they don't want to be in—either in the business of health insurance at all, or in a certain segment of the business.

We have seen a mass exodus of companies out of the individual insurance marketplace over the last several years. In fact, Mutual of Omaha has assumed a number of blocks of individual policies over the last number of years from some large carriers. We think it—if an insurer sees that they are not going to be in the health insurance business in the future, they should be allowed to get out of the business.

If they see that their financial solvency is being taxed and they have other insurance products that they provide and they need to get out, they should be allowed to get out of the business.

Mrs. COLLINS. Do you think there ought to be some kind of market exit rules that ought to be adopted to handle these kinds of cases?

Mr. BYKERK. Well, as I mentioned both in my written testimony and in what I mentioned, my statement today, we support portability, full portability of both individual policies as well as small group policies. And therefore if a company decides to get out of the business, those policyholders would have the option of going to other companies and getting coverage.

Mrs. COLLINS. Well, a final question, then, would be if a company does exit the market, should it be prohibited from reentering the market for some stipulated period of time?

Mr. BYKERK. Absolutely.

Mrs. COLLINS. Thank you.

Mr. Stearns.

Mr. STEARNS. Thank you, Madam Chairwoman. Just a personal question, Mr. Bykerk. You mention you favor both individual as well as employer mandates. Which of the two, if you had to make a choice, do you prefer?

Mr. BYKERK. Well, I guess our choice, of course, is both, but if I had to choose one, I would choose the individual mandate. The responsibility—

Mr. STEARNS. Why is that?

Mr. BYKERK. The responsibility should be on the individual to provide—

Mr. STEARNS. Personal responsibility?

Mr. BYKERK. Right. The employer mandate helps enforce the individual mandate. It is easier to enforce and police a mandate if it is provided through the employer as well. It is harder if it is left up to individuals.

An example is automobile insurance with mandates.

Mr. STEARNS. Either panelist can answer this question. You note that requiring health plans to apply equal increases across market segments for large groups, small groups and individuals would place those plans that offer coverage in all three markets at a competitive disadvantage. Could you please explain why? What alternatives would you suggest?

Mr. BYKERK. Well, if I could answer that first, we do operate in all three markets, and there are different dynamics within each marketplace. Tying them together allows a new carrier to come in that operates in just one of those sectors and to basically grab away the business because they are not limited or they don't have inflexible rules applied to them. And that is pretty straightforward what the problem is.

Mr. STEARNS. How do you feel about underwriting insurance plans based upon only three factors, age, sex and geography, as opposed to community ratings? Wouldn't this make the transition period smoother, fairer and, more importantly, on time?

Ms. FOX. We support community rating with age adjustments and geography adjustments, so, yes, we agree with you there.

Mr. STEARNS. You point out that requiring health plans to get prior approval for rate increases in excess of a certain amount essentially is a premium cap. Premium caps will make markets less predictable as health plans will be forced to respond to rising costs by changing the product design. For example, the benefits offered. Please elaborate further.

Ms. FOX. There are lots of problems with the way that provision works. First of all, the way Mr. Claxton described it would be prior approval and so it sounds, you know, less bad if it has prior approval, but there is no entity in the States there to respond to these types of requests in any timely fashion. And plus, it sends a signal that any amount above that is something that shouldn't be justified.

But the problem in trying to do that as a transition specifically is there are no standard benefit packages, so there is going to be different rate increases which are going to be appropriate based upon different benefit packages. If it is a rich package, it might have a higher rate of increase compared to a lesser rate of increase. Or if there is a carrier who just is very good at selecting good risks and he has a lot of healthy people in his pool, he might have a very low rate of increase as compared to a health plan like some of our plans that are right today taking all comers. And that would make our rate increases a lot higher. So I think there are lots of inequities the way this would be applied and creating is very problematic.

We think that you shouldn't do that and let the market, competition in the market, set the rates. We think that is the appropriate way and go towards community rating right away.

Mr. STEARNS. There is no correlation between the cost of providing coverage to the uninsured high risk population through the national high risk pool and the premiums charged by the signature

of HHS. There are no incentives for keeping cost equivalent to premiums charged. Also there are no requirements of actuarial soundness.

What do you think will be the end result without any safeguards attached to the government-run high risk pool?

Mr. BYKERK. Well, if I could comment on that, I think we have pointed out in our written testimony that, in fact, the minimum premiums that are set in the act would increase premiums in at least seven States that currently have high risk pools. Currently, seven States have lower premium maximums than are set as the minimum in the act's proposal. But we feel that the high risk pool is problematic at best, just on the grounds that you are going to implement something for a year or two and then take it all away.

Mr. Claxton was concerned about people being disrupted, companies going out of the business over the transition period, and yet they are going to put individuals in those 23 plus States that don't have high risk pools now. They are going to put those people into that very situation by giving them insurance through the high risk pool and then taking it away from them in a year or two.

Our proposal is to have some kind of guarantee issue if at the individual level we feel like it should be limited to a period, a specified period during the year.

Mr. STEARNS. Thank you, Madam Chairwoman.

Mrs. COLLINS. Mr. Greenwood.

Mr. GREENWOOD. Thank you, Madam Chairwoman.

My questions are directed to you, Mr. Bykerk. On page 3 of your testimony you say that insurance companies should be allowed to exit lines of business or cancel blocks of business. If one of the purposes of health care reform is to increase coverage, why does it make sense to allow companies to cut back on coverage that is already in force?

Mr. BYKERK. Well, again, I think it comes back to the free enterprise system of allowing companies to get out of the business if they want to. I believe that most industries, if you are a hardware store, if you want to close up shop, you are allowed to do that.

Now, I understand that in the insurance business we have a certain obligation to our policyholders. We have sold them insurance, we intend to be there, we hope to be there. But with the transition coming down the line, with the new environment ahead, if we sit back and say that we don't see a role for ourselves in the future or if during the transition the various premium rules don't allow us to avoid substantial losses, we should be allowed to get out of the business.

With respect to reducing availability of coverage, we would propose that there be some kind of a mechanism that people can move over to other carriers.

Mr. GREENWOOD. Don't the same theories of the free enterprise system suggest that employers should have the freedom to decide whether to provide coverage for their employees or not? Do you support the employer mandate?

Mr. BYKERK. Well, that was a very, very difficult—

Mr. GREENWOOD. Is that the gander or the goose?

Mr. BYKERK. I understand. That was a very, very difficult decision for our company to come to. We came to that on the basis that

if the objective is universal coverage, we will never get to universal coverage unless people are mandated to get there. We also, in saying that employers—in supporting an employer mandate, have not specified what contribution the employer has to make to the coverage. We are not necessarily saying it has to be 80 percent or 7.9 percent of payroll, whatever. But as I said before, our first focus as an individual mandate, the employer mandate really helps enforce it and police it.

Mr. GREENWOOD. I think probably the same ends could be used to justify the means in both instances. You point out on page 4 of your testimony that H.R. 3600 does not provide guidelines for the conversion of existing insurance coverage to the new standard benefit package.

Could this be a problem since some people might be reluctant to trade in the coverage they are familiar with for a new, untested system, leaving insurance companies holding the bag? How would you deal with this problem?

Mr. BYKERK. Well, we would propose that depending on what the ultimate system is, and let's assume for the moment, although we don't totally agree with the President's proposal with respect to mandatory alliances, but let's suppose for the moment that it is some kind of an alliance structure that is the ultimate. There theoretically will be an open enrollment period of, I think, 90 days prior to any State coming on line.

We would feel that during that period of time the individual should be notified whether their current coverage will be a certified or qualified plan. If not, then they should be looking around to decide where they are going to go. If we have a voluntary alliance, this is particularly appropriate. If it is going to be a certified plan and that is known, we would like the writers and insurer to automatically convert their coverage to the new prescribed benefit package so that there is continuity there. But it does allow us to not get in a position of having dual coverage, which I think would probably be illegal.

And under the current act, the way it is written, we have no right to do anything with those people except continue to insure them.

Mr. GREENWOOD. OK. In your testimony you gave a pretty vivid description of what is happening to the insurance market in New York. Can you explain to me how much of a difference modified community rating would make and what other factors could possibly be implemented to bring that marketplace around?

Mr. BYKERK. Well, the two key factors, of course, in New York are the guarantee issue year-round and the pure community rating. And as illustrated in the testimony, you can see the various percentages of what people's rates went up and down.

A modified community rating with geography is allowed in New York, down to the county level. We would say that age is a very important element. And then beyond that, some kind of a—with respect to the individual marketplace, a limited guarantee issue during say 30 days during the year.

Mr. GREENWOOD. Thank you.

Thank you, Madam Chairwoman.

Mrs. COLLINS. There is very little discussion of reinsurance or risk adjustment in the transition rules in your testimony, neither one of your testimonies. Do you need to have—do you think we need to have either of these mechanisms during the transition period? I will start with you, Ms. Fox.

Ms. FOX. Well, we have been doing a lot of work in risk adjustment and, quite frankly, it isn't one that exists today. We think that you can require carriers to guarantee issue and go towards community rating with age adjustments without a risk adjuster. So we don't think that you need a risk adjuster to do guarantee issue or go towards community rating.

We think where you need—where we think it is critical that you have to have a risk adjuster before you can do it is converting the employer choice model to the individual choice. That is where we think it is critical, that you can't do without a good risk adjuster.

Mrs. COLLINS. Mr. Bykerk.

Mr. BYKERK. I think it partly depends on just how long the transition period is and to what extent the insurance reforms precede some of the other reforms of the marketplace. So to the extent that you are going to implement all the insurance reforms or most of the insurance reforms right up front, then you can get some dislocation of the marketplace, you can get some—through the various rules that are proposed, you could get some risk segmentation that really calls for reinsurance or risk adjustment.

On the other hand, if there is a more step-by-step, gradual approach, if the transition isn't very long, then there probably isn't a need for it. And, again, depending on what kind of guarantee issue mechanism that is out there is real important.

Mrs. COLLINS. Thank you very much. We certainly appreciate your testimony this morning. And you have full knowledge that your entire written testimony will be made a part of this record.

Our next panel will consist of Ms. Debra T. Ballen, who is a senior vice president for policy development and research with the American Insurance Association; Mr. Thomas A. Taylor, chairman, Special Task Force on Health Care Reform and Auto Insurance for the Alliance of American Insurers; and Mr. Robert Steggert, who is the vice president, casualty claims, Marriott International. Won't you come toward, please?

STATEMENTS OF DEBRA T. BALLEEN, SENIOR VICE PRESIDENT, AMERICAN INSURANCE ASSOCIATION; THOMAS TAYLOR, CHAIRMAN, SPECIAL TASK FORCE ON HEALTH CARE REFORM AND AUTO INSURANCE, ALLIANCE OF AMERICAN INSURERS; AND ROBERT STEGGERT, VICE PRESIDENT, CASUALTY CLAIMS, MARRIOTT INTERNATIONAL

Ms. BALLEEN. Good morning. I am Debra Ballen of the American Insurance Association. Thank you for inviting me to testify today. Your subcommittee has an important role in determining the application of national health care reform to property casualty insurance. My oral statement today will be limited to the workers' compensation aspects of H.R. 3600, but I request that my entire written statement be included in the record.

Mrs. COLLINS. Without objection all statements will be a part of the record.

Ms. BALLEEN. Thank you. In last week's State of the Union address, President Clinton pressed for passage of a health care reform bill that would guarantee coverage that can never be taken away. In fact, guaranteed universal coverage is the hallmark of the current workers' compensation system.

Workers' compensation is one of the oldest no-fault mechanisms in the country. Benefits include complete medical care as well as lost income support.

These benefits are intended to cover all economic losses associated with workplace injury or illness. But workers' compensation is more than a benefit delivery system. It is a disability management system designed to facilitate prompt return to meaningful employment. The system is heavily regulated by the States.

There is an employer mandate and all States have residual markets which guarantee coverage to all employers regardless of claims experience. Regulators utilize experience-based rating systems designed to encourage employers to invest in safe workplaces and provide safety training.

Employees who change jobs remain fully covered without regard to preexisting conditions. The States' heavy involvement in workers' compensation is also seen in the recent record of legislative reform activity. Last year alone, 16 States enacted significant modifications to their systems. Medical cost containment has been a critical area of this focus.

In addition, over the past several years, insurers have taken affirmative steps to control costs and have registered impressive savings through the use of managed-care networks, utilization review, bill audits, and other cost containment measures.

AIA believes that national health care reform offers the potential for further streamlining the medical care component of workers' compensation through careful coordination of the new Federal health plans with State-based workers' compensation systems.

By contrast, we strongly oppose merger which would wreck existing workers' compensation systems by severing their medical component and incorporating it into the new Federal plans. This approach would increase costs and reduce safety incentives, but provide no benefit to injured workers or their employers.

Most of the health care reform bills introduced to date have taken a third approach, which is to exclude workers' compensation either explicitly or implicitly. We are in the process of studying the cost-shifting implications of this approach.

Getting back to H.R. 3600, the bill adopts a coordination framework, but it must be significantly improved if it is going to work well and achieve savings. In its current form, the bill would reverse the progress in managed care that is being made at the State level. The primary area for improving the proposal relates to the extent to which managed care is permitted.

As currently drafted, the bill prohibits insurers and employers from directing injured employees to appropriate providers, and from instituting hands-on claims management. Such limitations will result in increased costs for medical care, doctor shopping and longer periods of disability.

Most States, on the other hand, recognize the value of insurer involvement. About half authorize insurers or employers to select

providers, and a number of others have recently enacted legislation which allows insurers and employers to designate a certified managed-care organization.

The bill explicitly preempts important State laws which have sought to balance the needs of employers, injured employees and insurers alike. Strangely, we disagree with Mr. Claxton's assertion that these laws don't make a difference.

As Mr. Claxton testified, title X attempts to compensate for the absence of insurer-employer involvement through the use of fee schedules, certification standards, designated coordinators, and reporting requirements.

We firmly believe that these close controls will be of limited value and could add new costs to the system. They are no substitute for true managed care by workers' compensation insurers or employers. I also would like to comment on the commission which would be created to study the merger approach.

While we are really confident that a neutral analysis will identify the fundamental weaknesses in a merged system, we believe that this particular commission will be unfairly structured and predisposed in favor of merger. Statements by the White House have indicated as much.

If a commission is, in fact, established, this subcommittee should be involved to ensure full and objective review.

In conclusion, we appreciate the opportunity to testify today, and I am happy to answer any questions you might have.

[The prepared statement of Ms. Ballen follows:]

**U.S. HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON COMMERCE, CONSUMER PROTECTION,
AND COMPETITIVENESS
HEARING ON TITLES X & XI OF H.R. 3600
FEBRUARY 1, 1994**

AMERICAN INSURANCE ASSOCIATION

Good morning. My name is Debra Ballen, and I am Senior Vice President, Policy Development and Research, at the American Insurance Association. I would like to thank the members of this Subcommittee for the opportunity to appear before you to present AIA's perspective on health care reform.

AIA is a trade association of approximately 250 property/casualty insurance companies, writing about 25% of all such insurance sold in the United States. AIA has a vital interest in the relationship of national health care reform to our two largest lines of business--workers' compensation and automobile insurance. AIA recognizes the on-going interest of the Energy and Commerce Committee, and its Subcommittees, in issues affecting property/casualty insurance companies and believe you have an important role to play in determining the applicability of national health care reform legislation to our industry.

According to the Insurance Services Office ("ISO"), total incurred medical costs for the property/casualty insurance industry totalled approximately \$29 billion in 1992. While this is a relatively small share (approximately 4%) of total medical expenditures in the United States, the decisions you will be making in these areas will have profound implications for millions of claimants and policyholders.

Overview of Current Systems

Workers' compensation and automobile insurance are proven systems that have been developed, administered, and refined by the states.

Workers' compensation is one of the oldest social insurance mechanisms in the country, providing "no fault" coverage for work-related injuries and illnesses. Benefits include complete medical care without deductibles, copayments, dollar limits, or time restrictions, as well as income support, rehabilitation, and burial expenses. These benefits are intended to cover all of the economic losses associated with a workplace injury or illness. But workers' compensation is more than a benefit delivery system. It is a disability management system, the purpose of which is to facilitate prompt return to meaningful employment. In this regard, medical treatment decisions are heavily influenced by the need to maximize medical recovery as quickly as possible.

Automobile insurance provides compensation for injuries to people and losses to property that result from automobile accidents. When payments are provided through first party coverage, an injured person receiving medical care files a claim directly with his or her insurance company. This is the case in states with no fault laws and, on a more limited basis, in other states through the purchase of "medical payments" coverage. When payments are provided on a third party basis, the injured person must prove that another driver was "at fault." The settlement of successful liability claims often involves payments for both economic (e.g., lost wages and medical treatments) and non-economic (e.g., pain and suffering) losses.

Both workers' compensation and automobile insurance are heavily regulated by the states with respect to the coverages supplied to policyholders, the rates charged by insurers, and the claims settlement services provided to claimants. Most states have mandatory purchase requirements, and all states have public or private residual markets which guarantee availability to all policyholders, regardless of prior claims experience. Both workers' compensation and automobile insurance utilize rating systems which reflect both the risk profile and individual claims experience of each policyholder. And, employees who change jobs or retire from employment remain fully covered under workers' compensation, without regard to pre-existing conditions. It is interesting to note that many of the goals of national health care reform--such as universal access, comprehensive coverage, and portability--are

already built into the workers' compensation and automobile insurance systems.

I do not mean by this brief description to suggest that either system is perfect. Over the past decade, both the workers' compensation and automobile insurance systems have experienced rapidly escalating costs, driven by a number of factors, including: the accelerating cost of medical care; greater claims frequency; increased incidence of litigation; and expansion of the scope of injury the system is called upon to compensate.

Fortunately, there has been progress, as well. In the past several years, a significant number of states have taken affirmative steps to address these problems, targeting medical cost containment as an important area of focus, particularly for workers' compensation. For example, in early November, Florida, one of the nation's largest workers' compensation systems, enacted comprehensive workers' compensation legislation that included extensive medical reforms.

While AIA's role is to focus on legislative/regulatory reform, we are also aware that, over the past several years, our member companies have individually taken affirmative steps to increase the use of managed care in workers' compensation and have registered some impressive cost savings through the use of managed care networks, utilization review, bill audits, and other cost containment measures.

Relationship to National Health Care Reform

AIA believes that national health care reform offers the potential for further streamlining the medical care component of workers' compensation and automobile insurance. We support the careful "coordination" of new federal health plans with the compensation systems under the stewardship of our industry. A well-designed coordinated system, along the lines I will describe, provides the greatest promise for both improving medical care for our claimants and reducing costs for our policyholders.

By contrast, we strongly oppose the "merger" approach, which would wreck existing workers' compensation and automobile insurance systems by severing their medical component and "merging" them into the new health care system. This approach would increase costs and reduce safety incentives--but provide no benefit to injured workers or employers in the case of workers' compensation, or motorists, passengers, and pedestrians covered by the automobile insurance system. Moreover, if workers' compensation and automobile insurance medical benefits are brought into the restructured health care system, Congress will have to find a way to finance more than \$40 billion in benefits that are currently provided through alternative compensation systems and have not been factored into current revenue estimates for the President's plan. Our opposition to the merger approach is shared by important members of the business community, including the National Federation of Independent Business, the U.S. Chamber of Commerce, and the National Association of Manufacturers. Each of these groups has released member polling data or position statements strongly critical of the merger approach.

Some of the health care reform bills introduced to date have taken a third approach, which is to exclude workers' compensation and automobile insurance, either explicitly or implicitly. This, in fact, is the approach taken by every major health care reform bill introduced in this Congress, with the exception of the Clinton plan, and one deserving of serious consideration. However, we are concerned about the potential cost shifting implications of such an exclusion, particularly if the health care delivery system is redesigned in a manner that creates new incentives and opportunities for providers to shift costs to property/casualty insurers. We are in the process of studying H.R. 3600, as well as alternative bills, in order to better understand these cost shifting implications.

H.R. 3600

H.R. 3600 adopts a coordination framework and provides the building blocks for an optimal system for the delivery of medical care to injured workers and motorists. However, we believe that the proposal needs to be significantly improved if it is going to work well

and achieve savings. In its current form, the bill represents a step backward from the progress in managed care that is being made both through state legislation and individual carrier efforts.

The primary area for improving the proposal relates to the extent to which workers' compensation insurers and self-insured employers can manage the care of workers' compensation patients. As currently drafted, the plan requires employees generally to receive all non-emergency occupational medical treatment from the same health plan they have selected for their other health care needs. Insurers and self-insured employers would be prohibited from channeling injured employees to appropriate providers and from instituting "hands on" claims management. AIA believes that such limitations will result in increased costs for medical care, doctor-shopping designed to increase the dollar "value" of the wage loss portion of claims, and the lengthening of time before an employee returns to a productive life.

Many states recognize the value that insurers and self-insured employers bring to the claims management process. About half of the states authorize the insurer/employer to make the initial choice of provider, and a number of traditional "employee choice" states have recently enacted legislation which allows insurers and self-insured employers to designate a certified managed care organization to provide the care to injured workers. The bill explicitly preempts these state laws which have sought to balance the needs of employers, injured employees, and insurers alike.

The proposal attempts to compensate for the absence of insurer/employer involvement in claims management through the use of various controls--fee schedules; certification standards; designated coordinators; and reporting requirements. While well-intentioned, these controls will be of limited value and some could add new costs to the system. They are no substitute for true managed care by the workers' compensation insurer or self-insured employer.

Fee Schedules: Workers' compensation fee schedules are an effective cost containment tool when they are set at the right level (neither too high or too low), enforced by a regulatory authority, and coupled with strict utilization controls. As currently drafted, the proposal contains none of these features. Moreover, the bill appears to give states and Regional Alliances the unilateral authority to substitute alternative payment methodologies, creating an enormous potential for cost shifting against property/casualty insurers.

Although the bill also allows negotiated agreements between health plans and workers' compensation carriers, it does not establish a level playing field for such negotiations. Since workers' compensation insurers and employers will not be able to influence the employees' selection of a health plan, there will be little incentive for the plans to negotiate terms that are fair for the workers' compensation carrier.

State Certification: In order to obtain state certification, a health plan would be required to demonstrate its ability to arrange for workers' compensation medical care, including rehabilitation and long-term services. While the certification requirement is an effort to address quality concerns, experience tells us that such regulatory standards are seldom effective in the absence of a market incentive to provide the highest quality care. Moreover, since total workers' compensation medical payments (through private insurance, state funds, and self-insurance) constitute less than 3% of medical expenditures in the United States, it is hard to believe that state certification of health plans will depend heavily on the plans' ability to service the needs of workers' compensation patients.

Designated Coordinators: The health plans also would be required to designate a "workers' compensation case manager" to coordinate care. This could duplicate case management already being provided by workers' compensation insurers and self-insured employers and thus add costs to the system. Moreover, because the plans will be under enormous pressure to reduce administrative expenses, they will not have an incentive to invest heavily in workers' compensation case management and coordination.

Reporting Requirements: Information related to provider and health plan performance in treating work-related injuries and illnesses (including return to work) is to be included in reporting information provided by the plans to regulatory authorities (and ultimately the public at large). Unfortunately, the workers' compensation insurer will have no opportunity to act on such information, given the constraints on provider selection I previously described.

In short, AIA does not believe that the controls set forth in the plan will be nearly as effective in containing costs as insurers and self-insured employers can be, if granted a role in the selection of the provider and the on-going management of the claim. Within this construct, we support reasonable safeguards to assure that injured workers are comfortable with the quality of their treatment. Such safeguards should be consistent with the on-going role of the state workers' compensation agencies, which provide informal assistance to injured workers and a forum for resolution of disputes should they arise.

I also would like to call the Committee's attention to the Commission which would be created to "study the feasibility and appropriateness" of transferring the financial responsibility for all medical benefits (including those now covered under workers' compensation and automobile insurance) to the new health system, as well as to provide a detailed plan as to how such a merger might be achieved. The Commission is to be appointed and staffed by the Administration and report to the President, with no apparent Congressional role. We are concerned that this commission will not engage in objective analysis but will be predisposed to recommending the merger approach. Recent statements by First Lady Hillary Rodham Clinton, as well as documents published by the White House, reveal that this conclusion has already been reached--according to an October 8 briefing book to Congress, for example, "in the long run, a federal commission will develop a detailed strategy to fully integrate the financing of workers' compensation benefits."

We are confident that a neutral analysis of the issues demonstrates the fundamental weaknesses of the merger approach. However, an analysis that is preprogrammed to ignore

the adverse cost and safety implications will make recommendations that do not make sense. If a Commission is established, Congress should be involved in the process to assure a full and objective review of the issues.

Guidelines for a Well-Coordinated System

We believe it is possible to design a coordinated system that meets the needs of all participants in the workers' compensation and automobile insurance systems and that is consistent with President Clinton's and Congress's goals for national health care reform. With this in mind, we offer the following suggestions:

- (1) The health care system should be coordinated with workers' compensation and automobile insurance, not merged with them;
- (2) Workers' compensation and automobile insurers should be able to select managed care networks and have a role in critical treatment decisions that may affect the speed of recovery;
- (3) Consistent with points (1) and (2), state laws should govern the resolution of disputes over medical treatment and the use of a particular physician or health care provider;
- (4) Workers' compensation insurers and automobile insurers should have explicit authority to engage in utilization review, use medical treatment protocols, prescribe generic drugs, use centralized pharmaceutical services, and adopt other cost containment measures;
- (5) Cost shifting to workers' compensation and automobile insurance for medical treatment should be explicitly prohibited; and
- (6) With regard to automobile insurance, specifically, duplicate recovery of medical costs should be eliminated by requiring that the proceeds from a liability award

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(through a tort action or the settlement of a case) be used to reimburse a health care provider for the costs of the medical treatment rendered in relation to the injury.

Conclusion

Your decisions with respect to the treatment of workers' compensation and automobile insurance by national health care reform legislation will have profound implications for the millions who depend on those systems for benefits and protection. We believe it is possible to design a "coordinated" system that meets the needs of all players and is consistent with the broader goals of health care reform. Such a system should build upon existing state efforts, and not displace them.

In closing, I want to thank this Committee again for the opportunity to share these comments and observations on health care reform and its relationship to property/casualty insurance. AIA is committed to working with you to ensure that health care reform is accomplished in a manner that is supportive of other public policy objectives served by different forms of property/casualty insurance, including solvency and consumer protection. I would be happy to respond to any questions you might have.

Mrs. COLLINS. Mr. Taylor.

STATEMENT OF THOMAS A. TAYLOR

Mr. TAYLOR. Madam Chairwoman, members of the subcommittee, ladies and gentlemen, my name is Thomas Taylor. I am chairman of the Alliance of American Insurers' Special Auto Insurance Health Care Reform Task Force. I am also executive vice president and chief operating officer for Amica Mutual Insurance Company.

We appreciate this opportunity to express our views on title X of the Health Security Act. The Alliance and our 214 member companies provide workers' compensation and auto insurance to millions of Americans. We administer the medical components of these coverages in a manner that assures timely, appropriate care.

While we support the goals of health care reform as articulated by President Clinton last fall, we believe reform should build on existing programs at the State level. Although State reforms are relatively new, they are beginning to yield positive results in both the workers' compensation and auto insurance arenas.

Casualty insurers pay a significant amount for medical care each year, equaling some \$29 billion annually. Yet, compared to the total universe of almost \$700 billion in health care costs, our portion seems relatively small. We, therefore, commend the subcommittee for realizing that our issues are more important to the overall health care debate than simple numbers might suggest, and for taking the time to examine the impact the Health Security Act could have on these complex systems.

Although Alliance member companies provide both auto and workers' compensation insurance, my background stems from the automobile insurance field. My written testimony addresses both auto and workers' comp. However, as requested by the subcommittee, my oral remarks will focus exclusively on auto insurance.

Title X of the Health Security Act would have a negative impact on our Nation's auto insurance system. Unfortunately, by reading subtitle C of title X, it appears that the administration's ultimate goal is full merger of auto medical into the health care system. That would be unworkable for many reasons. However, since my time is limited, I will confine my remarks to today's title X's view of coordination.

As currently drafted, title X ignores two pressing problems for auto insurers: duplicate medical payments for the same injury, and cost shifting. We strongly support efforts to end duplicate payments for medical care. Auto insurers expect to be—to reimburse individuals for medical costs associated with accidents. That is our job. However, it should not be our job, nor should it be the job of health insurers, to duplicate payments made by another insurer for a single medical procedure.

Let me just take a moment to focus on the issue of cost shifting. One of the best cost-shifting studies we have seen is a recent survey of a trauma center and hospital reimbursement conducted by the American Association for the Surgery of Trauma. Although the study focuses on workers' compensation, it is equally applicable to auto insurance.

The AAST report clearly exposes substantial cost shifting among payers. The AAST found that when workers' compensation insurers

were payers, hospital bills were reimbursed \$1.32 for every dollar of value medical treatment rendered. Medicaid reimbursed the hospitals at the rate of only 85 cents.

Why should casualty insurers pay 155 percent of what Medicaid pays for the same service? We are open to and will be willing to discuss innovative ideas as to how cost shifting could be corrected. Good effective public policy for auto insurance as it relates to health care reform should embody the following principles.

Auto insurance should continue as the primary source of payment for auto accident-related medical costs. Auto insurers should be allowed voluntary, universal access to all types of health care delivery systems. Cost shifting should be eliminated. Regulation of auto insurance should continue at the State level and duplicate payments for auto injuries should be curbed.

In recent years, many States have implemented programs designed to contain auto-related medical costs. For example, in Colorado, a program using managed care has produced annual savings of some \$25.6 million. About 14 companies participate in Colorado's no-fault cost containment program.

Florida, New York and New Jersey have also moved in this productive direction. Insurers have also had medical cost containment programs in their places of operation for years. It is nothing new. This is a sample of a medical cost containment guide that has been used at Amica Mutual for a number of years and every member of our staff dealing with medical claims has this as a desk aid. It covers peer review, utilization review, et cetera.

In conclusion, let me reaffirm the alliance's commitment to achieving medical cost containment without sacrificing quality medical care and rehabilitation which victims of auto and occupational accidents now receive through the State-based auto insurance and workers' compensation systems.

The road to health care reform is certainly long and bumpy. Our overall goal as an association is to actively participate in the debate and to be a positive force for change. Again, we appreciate the opportunity to present our views here today and I would be happy to entertain any questions. Thank you.

[Testimony resumes on p. 178.]

[The prepared statement of Mr. Taylor follows:]

TESTIMONY OF THOMAS TAYLOR

I. INTRODUCTION

Madame Chairwoman, members of the subcommittee, ladies and gentlemen, my name is Thomas Taylor. I am the chairman of the Alliance of American Insurers' Special Auto Insurance/Health Care Reform Task Force. I am also executive vice president and chief operating officer for Amica Mutual Insurance Company. We appreciate this opportunity to express our views on Title X of the Health Security Act.

The Alliance and its 214 members provide workers compensation and auto insurance products to millions of Americans. We administer the medical care component of these coverages in a manner that assures quality care given in a timely manner. We feel that we should continue to offer these products for two very basic reasons: we are efficient, and, through experience rating, we are able to internalize the costs of these systems.

While we support the broad goals of health care reform as articulated by President Clinton last fall, we believe that reform should build on existing programs at the state level in the case of workers compensation and automobile insurance. The states have been dealing with runaway medical inflation in workers compensation and auto insurance for a number of years. Although state reform efforts are relatively new, they are beginning to yield positive results in both the workers compensation and auto insurance arenas.

As you can see from the exhibits which are attached to my testimony, casualty insurance coverages, including automobile insurance and workers compensation, pay a significant amount for medical care each year. Total medical care expenditures by property/casualty liability insurance coverages equal some \$24.7 billion annually. Yet compared to our total universe of almost \$700 billion in health care costs, the property/casualty portion seems relatively small. For that reason, we commend the subcommittee for realizing that property/casualty issues are more important to the overall health care debate than simple numbers might suggest, and for taking the time to examine the effect which the President's legislation could have on these complex systems. Workers compensation and auto insurance are much more than medical care delivery mechanisms -- they also are disability management systems.

The Clinton Administration's Health Security Act (H.R. 3600/S. 1757) seeks to include, somehow, the medical components of property/casualty coverages. The 1,300-plus page bill is organized into 12 titles. Title X deals specifically with the integration of workers compensation and auto insurance.

II. AUTO INSURANCE

Title X of the Health Security Act, as currently drafted, would have a negative impact upon our nation's auto insurance system. Each year, auto insurers pay out some \$13.5 billion for medical treatment of those injured in auto accidents. In some cases, these payments are for first-party coverage, and in some cases, for third-party coverage. Twenty-six states have what is called "no-fault" insurance, where an individual's own insurer compensates their losses, regardless of who may have been at fault for an accident. No-fault is a proven method for reducing litigation. Under Title X, these twenty-six states might be forced to return to a third-party auto insurance system. As a result, litigation in those states -- and the substantial costs which inevitably accompany litigation -- would increase.

Because payment for medical services is a significant role for auto insurers, we recognize that there are problems with the medical component of auto insurance. As evidence of that fact, one need only note that the average amount paid for bodily injury claims due to auto accidents rose nearly 109 percent from 1982 through 1991. The costs we see often have been inflated by statutory constraints on insurers. Cost shifting and medically unnecessary procedures in some cases contribute to this problem.

The Clinton Administration health care reform plan deals with auto insurance medical benefits in two steps:

first, auto insurance medical would be "coordinated" with the new health care system, i.e., financing would remain with auto insurers, but delivery of medical benefits would come through the health insurance system; and,

second, a commission would study and devise a plan to fully integrate auto insurance medical benefits into the new national health care system (i.e., both financing and delivery of benefits would come through the health insurance system).

The asserted goal of the first step -- coordination of benefits -- is worthwhile. Coordination of auto insurance with a new national health care system is a sound, sensible idea, if it is done correctly. However, the approach which H.R. 3600/S. 1757 takes toward coordination is seriously defective. For example, the bill does not deal at all with the pressing problem of duplicate medical payments for the same injury, or the "collateral source rule" that makes such redundant payments possible.

The second step is far worse than the first. Merger of these two disparate systems would cause more problems than it would solve, and increase costs for business. Under merger, individuals with good driving records would end up subsidizing bad, drunk and dangerous drivers. Also, approximately 11 percent of each driver's auto insurance premium (the portion that is due to medical coverages) would be shifted onto their employer.

Then there is the Commission on Integration of Health Benefits. This commission, described in Subtitle C of Title X, is to study and report to the President by July 1, 1995, on the feasibility and appropriateness of transferring financial responsibility for all medical benefits, including those covered by workers compensation and auto insurance, to the health plans. Judging from the language used to describe the Commission and its charge, full merger of the medical component of workers compensation into the health insurance system is a foregone conclusion. This lack of impartiality is not in the best interest of auto insurance policyholders, workers or employers.

So, what do we want from health care reform with respect to auto insurance? Good, effective public policy for auto insurance as it relates to national health care reform should embody the following principles: 1) auto insurance medical coverage should continue as the primary source of payment for auto accident-related medical costs; 2) auto insurers should be allowed voluntary, universal access to all types of health care delivery systems; 3) cost shifting should be eliminated; 4) regulation of auto insurance, including the medical care components of first-party and third-party coverages, should continue to be based at the state level; and, 5) duplicate claims payments for auto injuries should be curbed.

Our third point, that cost shifting should be eliminated, deserves special amplification. Cost shifting occurs when medical care providers price their services according to the source of payment (including auto insurers), rather than the actual cost of care. One of the best cost shifting studies we have seen is a recent survey of trauma center and hospital reimbursement conducted by the American Association for the Surgery of Trauma (AAST). Although this study focuses on workers compensation, it is equally applicable to auto insurance, since auto insurers reimbursement rates typically track other casualty coverages.

The AAST report clearly exposes inequities in the current system of reimbursement by revealing substantial cost shifting among payers. For example, for every dollar of treatment rendered to a workers compensation claimant, trauma centers received \$1.30 in reimbursement. When commercial insurers were the payers, trauma centers received \$1.26 in reimbursement for every dollar of treatment rendered. All other payers -- particularly Medicare and Medicaid -- reimbursed the trauma centers for less than the actual cost of treatment rendered.

A similar pattern was found with respect to the reimbursement of hospitals. When workers compensation insurers were the payers, hospitals were reimbursed \$1.32 for every dollar of medical treatment rendered. For commercial insurers, the reimbursement rate was \$1.30 for every dollar of medical treatment rendered. Managed care payers reimbursed hospitals at a rate of 97¢, Medicare reimbursed at the rate of 93¢, and Medicaid reimbursed at the rate of 85¢. Why should workers compensation or auto insurers have to pay 155 percent of what Medicaid pays for the same service? Surely something can be done to deal with this situation. We are open to, and would be willing to discuss, innovative ideas as to how the cost shifting problem could be corrected.

Auto medical case management should be left with auto insurers, who have a direct financial interest in the outcome of a claim. Auto insurers also should have access to all types of medical delivery systems, especially managed care. We know from experience that managed care can save our policyholders money. At my company, Amica Mutual Insurance Company, we have a medical cost containment guide of which we are quite proud. It covers peer review, utilization review, hospital bill review and auditing, chiropractic review, rehabilitation and large case management. It is used by each and every member of our staff who deals with auto medical claims. This guide is nothing new, and other auto insurers have similar medical cost containment programs in place. In other words, where we are allowed to utilize managed care, we do.

In no-fault states, where medical dollar thresholds determine whether one may pursue a tort claim beyond no-fault benefits, managed care programs directly controlled by auto insurers have diminished the number of claims ending up in litigation. Risk-free and easy access to a federal health care system for treatment of auto injuries without diligent case management and careful utilization review likely would fuel auto tort claims and lead to additional litigation.

In addition, auto insurers must be given access to important data needed to accurately determine losses from auto accidents. Having ready access to medical care information through direct involvement in the claims process is a vital element of the auto injury claims settlement process. Medical damages serve as one of the key elements which determine the ultimate dollar settlement value of a tort claim. It is critical that an insurer's claims department have full, complete medical information at an early stage, in order to set aside sufficient funds (reserves) to meet future potential settlement obligations. Integration of auto medical into a new health insurance system poses a very serious threat to our ability to manage these cases.

If auto insurers are excluded from the medical process, or receive scant, inadequate or late medical information, the consequences could include under-reserving. This clearly presents the threat of insolvency, which, in turn, could lead to unsatisfied claims and quickly depleted state guaranty funds. Prompt, accurate reserve-setting is a key to any successful insurance operation.

We also strongly support efforts to end duplicate payments for medical care. Auto insurers expect to reimburse individuals for medical costs associated with auto accidents. That is our job, and the product our policyholders pay for. However, it should not be our job, nor should it be the job of health insurers, to pay a second time for a single medical procedure.

Further, Title X's call for a study commission to explore the integration of auto insurance should be deleted. A federal study is unnecessary, since the states are better positioned to address the diversity in their own marketplaces, as well as the needs of the public and the operations of local health plans.

In recent years, many states have implemented programs designed to contain auto-related medical costs. As proof of managed care's effectiveness in relation to auto insurance, I would draw your attention to Colorado's no-fault cost containment program. This program has successfully used managed care to reduce auto accident medical claims costs. Annual savings amount to some \$25.6 million. In a relatively small insurance market, about 14 companies participate in Colorado's no-fault cost containment option plan, which has been in place since 1991. Of the approximately 1.4 million drivers insured by those companies in Colorado, 45 percent participate in the plan. After only two years, participating insurers have reduced their no-fault premiums by 20 percent. Florida, New York and New Jersey are also moving in this promising direction.

III. WORKERS COMPENSATION

To begin our discussion of workers compensation, I would like to share some relevant statistics with the subcommittee. One hundred million Americans, or nine out of every ten workers, are covered by workers compensation insurance. Workers compensation costs business over \$60 billion annually. Over the past decade, more than \$128 billion in workers compensation benefits have been paid to over 16 million injured workers. During that same time, workers compensation medical costs rose 14 percent per year, compared to general health care costs, which rose only eight percent per year. According to Towers Perrin, at current trend rates, it is estimated that annual workers compensation direct costs will surpass \$140 billion by the year 2000.

American businesses, large and small, have sought ways to reduce their workers compensation costs for the past several years. Similarly, we in the insurance industry have been looking for ways to fix the few parts of the valuable state-based workers compensation system that have broken down. The states are now making real progress on the workers compensation front. Since 1989, 26 states have enacted legislation to update and strengthen their state-administered systems. Thirteen of these states (California, Colorado, Connecticut, Florida, Kansas, Louisiana, Maine, Massachusetts, New Mexico, Oregon, Pennsylvania, Rhode Island and Texas) are expected to see significant cost reductions as the direct result of reforms. A chart displaying the estimated cost savings on a state-by-basis is included in Exhibit Six, which is attached to my testimony. Hopefully, any national health care reform plan would support, rather than hinder, this progress.

The Alliance of American Insurers suggests the following goals for workers compensation as it relates to national health care reform: 1) workers compensation insurers should be allowed voluntary, universal access to all types of health care delivery systems; 2) cost shifting should be minimized; 3) regulation of workers compensation should continue to be based at the state level; 4) insurers or employers paying for medical care should have substantial control over decisions relating to that care; 5) experience rating should be maintained; and, 6) the exclusive remedy doctrine should be preserved.

Our analysis of Title X of the Health Security Act indicates that it would undermine goals 2, 3 and 4 as listed above. Title X also, in our view, would create an unworkable system that would fail to live up to the President's goals of efficiency, cost reduction and responsibility.

Without a doubt, unfair cost shifting -- which drives up the cost of medical care delivered through workers compensation -- should be prohibited in the new health care system. Cost shifting often occurs because the government reimburses providers of medical services at less than the going rate, causing those providers to shift the unreimbursed costs to private payers, such as workers compensation insurers, auto insurers and other private payers.

As I noted earlier, workers compensation insurers pay substantially more than regular health insurance to treat the same injury. According to the Workers Compensation Research Institute (WCRI), the average state Medicare fee schedule is 66 percent of the workers compensation fee schedule. According to another study by the Minnesota Department of Labor and Industry, for every dollar that Blue Cross pays to treat an injury, workers compensation coverage pays \$2.04. Ending this cost shifting would save millions of dollars for the workers compensation system. Employers would then be free to spend the savings on investing in plants and equipment, and hiring more workers.

Title X would impose federal jurisdiction upon state workers compensation systems. The states have been effective workers compensation regulators, taking appropriate steps to correct local market problems when and where they may occur. Health insurance reform should not serve as a vehicle for undermining state programs that work. Yet the Health Security Act would pre-empt several valuable state laws, including those related to physician choice, changing medical providers, the number of providers, physical referrals, and other state workers compensation laws dealing with who can treat an occupational injury.

The Clinton Administration's "coordinated" approach to workers compensation, as outlined in H.R. 3600/S. 1757, also is flawed because it requires, rather than allows, medical treatment for occupational injuries to be delivered through the employee's health insurance plan, leaving employers with no input into the choice of a medical provider. Title X would shift case management of an injury away from the employer/insurer -- who has expertise in this area -- to the health insurance plan, where there is no expertise.

Shifting medical management of an injury from the employer/insurer to the health insurance plan could increase lost productivity and drive up indemnity costs. The party with the financial stake in a swift return to work (employer/comp insurer who provides indemnity) would have no power to direct treatment toward optimal return to work. The party with the power to direct treatment (health insurer via case manager) would have no financial incentive to speed return to work. In fact, the health insurer would have several incentives to minimize treatment, increasing the workers length of time away from the job.

It is estimated by some workers compensation experts that an increase in duration of disability of just one day in each week of lost time will add \$10 billion to the cost of workers compensation. The First Lady and head of the president's health care task force, Hillary Rodham Clinton, has estimated that the president's plan will save, at best, \$6 billion in workers compensation medical costs. So, even if the First Lady is correct, and our single-day added theory is also correct, we start off \$4 billion in the hole. If her estimated savings are off slightly, and ours are also off slightly -- meaning that two or more days are added to disability -- the additional cost becomes ever scarier.

The WCRI recently released an assessment of the implications of the Health Security Act for workers compensation costs. WCRI was only able to roughly quantify a few of the cost impacts. They did not venture to estimate the cost impacts of disconnecting responsibility for medical and indemnity benefits or the use of specialized workers compensation providers. Nevertheless, WCRI estimates that under this proposal, the cost to employers for workers compensation could increase between \$7 billion and \$9 billion with considerable leeway above and beyond that range.

On the other hand, analyses of recent workers compensation reforms undertaken at the state level are producing very impressive results. State-based reform packages often include provisions allowing workers compensation carriers to have nondiscriminatory access to managed care arrangements, which can substantially reduce medical costs. Currently, only 22 states have authorized the use of, or experimentation with, managed care in workers compensation claims. Health care reform could make it possible for employers and employees in every state to have the benefit of occupational managed care. Despite the statutory limitations, the use of managed care is growing among workers compensation providers wherever possible. In large part, these techniques work to reduce costs because of the connection between medical treatment and disability management that currently exists.

A recent study by Towers Perrin indicates that approximately 50 percent of employers/workers compensation insurers are using health maintenance organizations, preferred provider organizations, or other managed care networks for workers compensation. This figure is up from only 20 percent in 1991. Utilization review also increased dramatically, from 28 percent in 1991 to 70 percent in 1993. Pre-certification of medical treatment tripled from 19 percent to 57 percent, and case management increased from 30 percent to 84 percent.

It should be recognized that workers compensation insurance is a completely different product than first-party health insurance. The goal of health insurance is to return an individual to health. The twin goals of workers compensation are to quickly return an individual both to work and to health. Also, workers compensation provides first-dollar medical coverage, whereas health insurance draws upon individual employee financial contributions in the form of premiums, deductibles and co-payments. Because of these fundamental differences, merging the two systems without sacrificing efficiency and quality of medical care would be extremely difficult.

IV. CONCLUSION

Title X is flawed, as currently written. However, there is something President Clinton and the Congress could do to directly benefit employers, workers, and individuals who purchase auto insurance. Health care reform legislation should contain "all-payer" language to deal with unfair cost shifting. Our members believe that they can compete with anyone in the management of medical care, including utilization control, if they are allowed to do so. All-payer language would level the playing field, and finally give casualty insurers a chance to do what they do best -- serve our customers.

Let me briefly explain what I am suggesting. The potential for cost shifting increases when the networks envisioned by the Health Security Act combine the functions of health insurer and health care provider. As a result, it may be necessary to seek legislative protection against charging workers compensation and auto insurers more for medical services than is warranted by the cost of providing those services.

One approach to such protection would be to require that the new health care system guarantee that health care providers (whether or not they are within a network) can only charge casualty insurers at the same rate they charge health insurers. If there is a capitated arrangement between a provider and health insurer, then casualty insurers should pay the equivalent of the provider's cost of performing a service, including a profit margin equivalent to that under the capitation arrangement.

Providers should post these fee equivalents for their range of services. The charge for treating a broken arm should therefore be the same, whether paid for by health insurance or casualty insurance. If a casualty insurer requests additional services or a more intensive treatment schedule, then the casualty insurer also would pay reasonable costs associated with the additional services. If a casualty insurer directed an injured person to a care facility outside of the individual's health care network, then that insurer should pay whatever fee it negotiates with the out-of-network provider.

Federal involvement in the regulation of casualty insurance should be discouraged to the extent that the right to engage in price competition without any payer having a built-in competitive advantage can be achieved without direct federal intervention. A standard promulgated at the federal level requiring uniform treatment of payers, enforced at the state level, would be acceptable if needed to avoid cost shifting and to promote competition, although other federal solutions also may be acceptable.

In conclusion, I would like to reaffirm the Alliance's commitment to achieving medical cost containment, without sacrificing the quality medical care and rehabilitation which victims of auto and occupational accidents now receive through the state-based auto insurance and workers compensation systems. The road to health care reform is certain to be long and bumpy. Our overall goal as an association is to actively participate in the debate, and be a positive force for change.

Again, we appreciate the opportunity to present our views here today. I would be happy to answer any questions you may have.

EXHIBIT ONE

**PRICE INDICES FOR AUTO INSURANCE AND RELATED ITEMS
AND ANNUAL RATES OF CHANGE, 1983-1992**

(Base: 1982-1984=100)

Medical care items			Hospital rooms		Physicians' fees		Auto Insurance	
Year	Index	% change	Index	% change	Index	% change	Index	% change
1983	100.6	+8.8	100.6	+11.3	100.1	+7.8	100.4	+9.8
1984	106.8	+6.2	109.0	+8.3	107.0	+6.9	108.2	+7.8
1985	113.5	+6.3	115.4	+5.9	113.3	+5.9	119.2	+10.2
1986	122.0	+7.5	122.3	+6.0	121.5	+7.2	135.0	+13.3
1987	130.1	+6.6	131.1	+7.2	130.4	+7.3	146.2	+8.3
1988	138.6	+6.5	143.3	+9.3	139.8	+7.2	156.6	+7.1
1989	149.3	+7.7	158.1	+10.3	150.1	+7.4	166.6	+6.4
1990	162.8	+9.0	175.4	+10.9	160.8	+7.1	177.9	+6.8
1991	177.0	+8.7	191.9	+9.4	170.5	+6.0	191.5	+7.6
1992	190.1	+7.4	208.7	+8.8	181.2	+6.3	205.5	+7.3
% change, 1983-1992		+89.0			+107.5		+81.0	+104.7

Source: I.I.I. 1994 Fact Book.

EXHIBIT TWO

HEALTH INSURANCE BENEFITS PAYMENTS, 1990-1991

(in millions of dollars)

	1991	1990	% change
Private insurers	\$97,600	\$92,500	+5.5
Blue Cross/Blue Shield	60,000	55,900	+7.3
Other plans*	112,000	93,400	+19.9
Private sector total**	222,400	208,900	+6.5
Medicare	114,000	107,200	+6.3
Medicaid	76,900	64,800	+18.7
Public sector total	190,000	172,000	+10.5
Totals	\$413,300	\$380,900	+8.5

*Includes self-insurers, Health Maintenance Organizations, employer-employee sponsored plans, etc.

**Some duplications in figures.

Source: Health Insurance Association of America; U.S. Health Care Financing Administration
The I.I.I. 1994 Fact Book.

EXHIBIT THREE

COMMERCIAL AUTOMOBILE INSURANCE, 1983-1992

(in thousands of dollars)

Year	Liability			Collision and comprehensive		
	Premiums written	Annual %change	Combined ratio*	Premiums written	Annual %change	Combined ratio*
1983	\$4,736,128	-0.1	132.0	\$2,773,199	+2.2	105.9
1984	5,407,281	+14.2	142.4	3,268,035	+17.8	110.9
1985	7,842,789	+45.0	126.3	4,066,138	+24.4	97.1
1986	11,108,002	+41.6	111.6	5,106,615	+25.6	82.1
1987	11,755,444	+5.8	107.1	5,157,198	+1.0	79.4
1988	11,707,484	-0.4	107.5	5,182,808	+0.5	80.4
1989	12,047,151	+2.9	111.5	5,259,759	+1.4	85.4
1990	12,211,706	+1.4	113.7	4,762,688	-9.3	90.4
1991	12,118,029	-0.8	112.3	4,444,243	-6.7	86.7
1992	11,882,912	-1.9	110.1	4,190,789	-5.7	89.3

*Before dividends to policyholders.

Source: A.M. Best Company, Inc., Best's Aggregates & Averages.

The I.I.L. 1994 Fact Book.

EXHIBIT FOUR

TOTAL NET PREMIUMS WRITTEN BY PROPERTY AND
CASUALTY INSURANCE COMPANIES, 1983-1992

(in thousands of dollars)

Year	Accident and health	All other	Total	Annual % change
1983	\$4,347,760	\$104,635,048	\$108,982,808	+ 4.8
1984	3,836,695	114,329,616	118,166,311	+ 8.4
1985	3,205,359	140,981,061	144,186,420	+22.0
1986	2,929,510	173,622,560	176,552,070	+22.4
1987	3,814,711	189,431,068	193,245,779	+ 9.5
1988	4,699,179	197,315,519	202,014,698	+ 4.5
1989	4,579,572	203,808,381	208,387,953	+ 3.2
1990	4,947,959	212,876,881	217,824,840	+ 4.5
1991	5,147,169	217,844,019	222,991,188	+ 2.4
1992	5,383,911	222,116,187	227,500,098	+ 2.0

Source: A.M. Best Company, Inc., Best's Aggregates & Averages.
The I.I.I. 1994 Fact Book

EXHIBIT FIVE

PRIVATE PASSENGER AUTOMOBILE INSURANCE, 1983-1992

(in thousands of dollars)

Year	Liability			Collision and comprehensive		
	Premiums written	Annual %change	Combined ratio*	Premiums written	Annual %change	Combined ratio*
1983	\$23,343,939	+8.6	111.0	\$16,974,304	+11.0	96.3
1984	24,809,382	+6.3	112.8	18,497,769	+9.0	100.6
1985	28,243,882	+13.8	118.9	21,180,583	+14.5	98.9
1986	32,972,920	+16.7	117.9	24,198,891	+14.3	93.6
1987	37,449,134	+13.6	116.1	26,838,193	+10.9	89.7
1988	40,812,744	+9.0	115.9	28,676,435	+6.8	92.0
1989	43,976,575	+7.8	117.0	29,585,442	+3.2	95.5
1990	47,830,741	+8.8	117.7	30,561,903	+3.3	93.9
1991	51,199,621	+7.0	113.3	31,555,090	+3.2	88.5
1992	55,472,647	+8.3	109.9	32,897,927	+4.3	87.7

*Before dividends to policyholders.

Source: A.M. Best Company, Inc., Best's Aggregates & Averages.

The I.I.I. 1994 Fact Book

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EXHIBIT SIX

HEALTH CARE AND STATE WORKERS COMPENSATION REFORMS

State workers compensation laws were created to provide a no-fault system to deliver prompt, quality medical care, and fair wage replacement to workers injured in the course of employment. These systems provide a complete disability management program that insures far more than the routine medical treatment of an injury or disease.

Since workers compensation system reform efforts began in earnest in 1989, twenty-six states have enacted legislation to update and strengthen their state-administered programs. Of those states, thirteen (California, Colorado, Connecticut, Florida, Kansas, Louisiana, Maine, Massachusetts, New Mexico, Oregon, Pennsylvania, Rhode Island and Texas) have implemented major reforms with expectations for significant cost reductions.

State workers compensation programs are now showing some real signs of improvement. In 1989, Texas passed sweeping changes to its workers compensation system. Since taking effect, these changes have produced real savings in medical expenses in workers compensation cases. The estimated total cost savings of the new law are over 30 percent.

Oregon passed major changes in 1990 using managed medical care as a leading reform strategy. As of the beginning of 1994, Oregon had experienced rate decreases for the past four years, which now totals over 34 percent.

Reform legislation in Colorado, in effect since July 1991, has cut that system's costs also. There was no increase in workers compensation costs in 1992 and there was a 5 percent reduction in costs in 1993 as a result of reform.

The positive effect of reform legislation passed in Massachusetts in December 1991 has resulted in an actual 10.2 percent reduction in costs. This is the first cost reduction in over 20 years. It follows four years of double digit increases.

Employers are more optimistic today about the future of workers compensation than they were just two years ago. According to a Towers Perrin survey, in 1991, three out of ten employers believed their workers compensation costs would be somewhat or completely out of control in five years. In 1993, only two in ten believed that would be the case.

The decisions made at the federal level pose a multitude of problems for state legislators and workers compensation commissions. Federal policy will affect the proper and timely medical treatment of injured workers, safety in the workplace, indemnity costs, return-to-work programs, current managed care arrangements, litigation, and administrative practices, all of which are being addressed at the state level. Neither the injured worker nor the employer will be served efficiently or effectively by these proposed federal changes.

State Workers Compensation Programs

Major Reform Enactments 1989-1993 Estimated Cost Savings

California	Estimated savings \$1.5 billion annually
Colorado	-24%
Connecticut	-19%
Florida	-25%
Kansas	-13%
Louisiana	-08%
Maine	-11%
Massachusetts	-10% actual cost reduction
New Mexico	-11%
Oregon	-34% actual cost reduction
Pennsylvania	-12%
Rhode Island	-28%
Texas	-30% actual cost reduction

Mrs. COLLINS. Thank you.
Mr. Steggert.

STATEMENT OF ROBERT STEGGERT

Mr. STEGGERT. Good morning, Madam Chairwoman and members of the subcommittee. I am Robert Steggert and with me today is Mark Stuart, who is the associate director of risk management for the National Association of Manufacturers.

I am the vice president of casualty claims for Marriott International, headquartered in Bethesda, Maryland. I appear today on behalf of the National Association of Manufacturers' Workers' Compensation Subcommittee and Risk Management Committee.

NAM is a voluntary business association of more than 12,000 member companies and subsidiaries, large and small, located in all 50 States. Members range in size from very large to more than 8,000 smaller manufacturing firms, each with fewer than 500 employees. NAM members employ 85 percent of all workers in manufacturing and produce more than 80 percent of the Nation's manufactured goods.

NAM is also affiliated with an additional 158,000 businesses through its Association Council and the National Industrial Council.

Madam Chairwoman, I would like to thank the committee today for having the opportunity to discuss title X of H.R. 3600 and the administration's proposal to integrate particularly workers' comp into the national health care plan. The problems with workers' compensation perennially dominate NAM surveys of both large and small manufacturers.

Traditionally, NAM has long opposed Federal involvement in any way in the State-run workers' compensation programs. This remains current NAM policy. However, we have been willing to discuss the idea to improve workers' compensation systems within the context of the national health care plan. We continue to evaluate the administration's entire health care proposal and our ultimate position on workers' compensation will depend heavily on our position on health care reform.

I would also like to say the current system, although jeopardized by rapidly rising costs, still serves the majority of claimants well. It is a minority of cases, coupled with systemic abuse and fraud that has driven up costs for everyone.

On the latter issue of fraud, there is some timely information just out of California last week. The L.A. district attorney made nine arrests in the classic California mill. That enterprise included doctors, lawyers, a number of other individuals.

To give you a sense of the state of the problem in California, insurance offices estimate that there were 35,000 individual fraud claims generated by this single Los Angeles mill in the last 18 months, with the crime totaling over \$300 million. That is one of 370 plus current investigations going on Statewide in the State of California.

The members of the National Association of Manufacturers have previously expressed concern with the rising costs of health care and the high numbers of uninsured Americans. We also are con

cerned with the cost impact the changes in the health care system would have on the workers' compensation system.

After careful study of the President's reform proposal as it affects workers' compensation, NAM's Workers' Compensation Subcommittee and Risk Management Committee have adopted a resolution that states this complex issue deserves separate and distinct attention from the health care system.

Title X would jeopardize successful workers' compensation reform efforts at the State level, particularly as it relates to cost mechanisms. The proposed changes, among other things, eliminates employer choice of provider, and diminish the employer input in control of case management.

Of greatest concern is the Federal Commission called for in title X, which apparently is intended to federalize the entire workers' compensation system. NAM believes that any federalization of programs would be a serious error. At the same level, the benefits can best be tailored to fit—at the State level, excuse me, benefits can best be tailored to fit local socioeconomic conditions and such situations as may arise as the result of the introduction of new industries and technologies. Therefore, workers' compensation should continue to be regulated and administered by the State without intervention of the Federal Government.

Some of the current troubling aspects of the system and contentious ones include the choice of physician. The value of allowing the free selection of physician is debatable. However, we have seen no evidence to support that this is preferable in workers' compensation cases. Most employees do not have the training, knowledge, or information necessary to make informed decisions, particularly in instances requiring specialists and rehabilitation.

The proposal allowing States to certify specialists available to injured workers outside their basic health plan would facilitate doctor shopping and create additional disputes over medical treatments. Currently, although half the States are split between employer and employee choice of physician, under title X this would be preempted and employers would have no control and in some cases no input in that decision.

We believe there is value to the employer input in the choice of physician and that the employee is better served if he or she makes that decision in conjunction with their employer. The system has allowed—if the system allows employees to switch doctors, it is likely to result in unnecessary lengthening of disability periods, impairment ratings and ultimately cost.

The bill, as substantially written, reduces the ability of the employer to control treatment, and this, coupled with free choice of physician, could result in treatment by inappropriate providers and providers lacking appropriate training for occupational injuries. In any case, it does nothing to enhance or maintain the quality of treatment available to the injured workers.

Case management is also an issue of discussion. It is critical to the successful treatment of serious injuries in order to speed recovery and allow a timely return to work. The case manager, most importantly, needs to understand the specific injuries and jobs of an individual in order to effectively communicate with the physicians.

Very briefly, on cost shifting, we fear that the incentives in this bill to employers to shift cases to workers' compensation in a noncapitated system could result in additional cost shifting to workers' compensation.

Mrs. COLLINS. Mr. Steggert, I am almost sure that whatever else you want to say during your testimony will come out during the question and answer period.

Mr. STEGGERT. Thank you very much.

[The prepared statement of Mr. Steggert follows:]

STATEMENT OF ROBERT STEGGERT

Good morning, Madam Chairwoman and members of the subcommittee. I am Robert Steggert and with me today is Mark Stuart, associate director of risk management for the National Association of Manufacturers.

I am the vice president of casualty claims for Marriott International, based in Bethesda, Maryland. I appear today on behalf of the NAM's Workers' Compensation Subcommittee and Risk Management Committee.

The National Association of Manufacturers is a voluntary business association of more than 12,000 member companies and subsidiaries, large and small, located in every State. Members range in size from the very large to the more than 8,000 smaller manufacturing firms, each with fewer than 500 employees. NAM members employ 85 percent of all workers in manufacturing and produce more than 80 percent of the Nation's manufactured goods. The NAM is affiliated with an additional 158,000 businesses through its Associations Council and the National Industrial Council.

Madam Chairwoman, I'd like to thank you and the subcommittee today for the opportunity to discuss title X of H.R. 3600, the administration's proposal to integrate the medical component of workers' compensation into a national health care plan. The problems associated with workers' compensation perennially dominate NAM surveys of both small and large manufacturers.

Traditionally, the NAM has long opposed Federal involvement, in any way, in the State-run workers' compensation system. This remains current NAM policy. However, we have been willing to discuss ideas that improve the workers' compensation system within the context of a national health care plan. We continue to evaluate the administration's entire health care proposal, and our ultimate position on workers' compensation will depend heavily on our position on health care reform. I would also like to say that the current system, although jeopardized by rapidly rising costs, still serves the majority of claimants well. It is a minority of cases that has driven costs up for everyone.

The NAM is concerned about the rising costs of health care (97 percent of our members provide it as part of their basic benefits package), as well as the increasing number of uninsured Americans. The high costs of health insurance make it increasingly difficult for Americans to compete globally.

We are also very concerned about sharp increases in the costs of workers' compensation which threaten the viability of many employers. Medical costs are rising faster in these programs than in general health care. Of the approximately \$70 billion spent last year on workers' compensation premiums, 60 percent of the costs were spent to reimburse injured workers for lost wages and impairment. The remaining 40 percent covered medical costs, which were exacerbated by the fact that workers' compensation medical coverage is virtually unlimited in dollar amount and duration, without deductibles or co-payments, and subject to cost-shifting by providers to the workers' compensation system.

More than providing indemnity payments and medical care, workers' compensation is primarily a rehabilitation program. The goal of workers' compensation is to promptly restore an injured employee to his or her health and productivity. Prompt, high-quality medical treatment for injured workers must be provided with this critical goal in mind. The most successful programs feature the ongoing involvement of the employer to ensure that the employee is fully supported in his or her total medical care and return to employment. Employer involvement ensures that, when possible, jobs are modified to foster rehabilitation and an early return to work.

Workers' compensation is also unique in that it provides all medical care at no cost to the employee. Full medical care is provided for the duration of the work-related injury or illness, regardless of where he or she may be employed. It can include physical therapy, chiropractic care, vocational rehabilitation and other services beyond the scope of many health plans. As government-funded plans such as

Medicare and group health plans intensified cost-containment efforts over the past decade (which have limited reimbursement levels and services available), there has been a dramatic cost-shift to workers' compensation. In addition to receiving payment for lost wages (indemnity benefits), employees know they can receive more treatment—often by physicians of their choice at no cost—through the current workers' compensation system. As a result, medical providers, facing stringent fee schedules and discounts in Medicare and group health care plans, often treat workers' compensation claimants with greater frequency and at significantly higher rates.

Both the emphasis on return to employment and the provision of comprehensive medical care at no cost to the employee, which are long-standing features of our Nation's workers' compensation system, need to be understood in any proposal to include workers' compensation medical services in a national health care-reform package. While the costs of workers' compensation medical services are an increasingly important expense component, the majority of the workers' compensation expense is still devoted to providing benefits related to time lost from work (which also needs to be effectively controlled). As a consequence, an employers' current ability to influence medical treatment decisions, thereby facilitating rehabilitation and an employee's speedy return to work, must not be compromised in any new proposal.

NAM members applaud reform efforts at both the State and Federal level. Programs that contain costs, both in group health care and workers' compensation health care, would represent a substantial improvement over the current system. But workers' compensation has unique features that cannot be ignored if any reforms are to succeed.

As is widely known, the White House has proposed to reform the Nation's health-care system, which would include the medical treatment of workers' compensation. Under the administration's proposal, an injured worker would seek treatment from a provider participating in the health plan in which he/she is enrolled. For companies that self-insure their workers' compensation programs, the health plan will be one of the three or more plans directly or indirectly selected by his/her employer under the overall regional/corporate alliance system.

Under this plan, the health plan provider would treat the worker whether the injury is work-related or not. If the injury is work-related, the health plan will bill the employer (if self-insured) or the employer's insurance carrier (if coverage is purchased on the open market) for the care provided. The rate of reimbursement is to be at the alliance fee-for-service schedule unless another fee is negotiated with the health plan. To that extent, costshifting could be reduced, if the fee-for-service schedule is similar to the cost of providing similar services under general health care. This appears to be the goal of the program.

The issue of work-relatedness and extent of compensable injury are to be determined under state compensation law, which appears to mean through the workers' compensation adjudication process. In practice, in contested cases no reimbursement should be paid until the state adjudication process has made the compensability determination. Thus, reimbursement claims of health plans/alliances stand in the same shoes as claims of medical providers under existing workers' compensation laws. The only difference is that the amounts may be lower under the proposal because of previously negotiated rates that cut costs through negotiations, which may be lower than the prescribed fee schedule.

Employers would not be "relieved" of their current statutory obligation to pay separate insurance premiums (or to self-insure) to indemnify employees for lost wages.

The members of the NAM have previously expressed concern with the rising costs of health care and the high numbers of uninsured Americans. We are also concerned about the cost impact that changes to the health care system would have on the workers' compensation system. After careful study of the President's reform proposal as it affects workers' compensation (title X), the NAM's Workers' Compensation Subcommittee and Risk Management Committee have adopted a resolution that states that this complex issue deserves separate attention from that of the health care system.

Title X would jeopardize successful workers' compensation reform efforts at the state level, particularly as they relate to cost control mechanisms. The proposal would, among other things, eliminate employer choice of provider and diminish employer input and control of case management. Of greatest concern is the Federal Commission called for in title X which apparently is intended to federalize the entire workers' compensation system. The NAM believes that any federalization of these programs would be a serious error. At the state level, the benefits can best be tailored to fit local socioeconomic conditions and such situations as may arise as the result of the introduction of new industries and technologies. Therefore, workers' compensation should continue to be regulated and administered by the States with-

out intervention by the Federal government. Outlined below in greater detail are some of our concerns:

Choice of physician: The value of allowing the free selection of physician is debatable. We have seen no evidence to support that this is preferable in workers' compensation cases. Most employees do not have the training, knowledge or information necessary to make these decisions, particularly in instances requiring specialists and rehabilitation. The proposal allowing states to certify specialists available to injured workers outside their basic Alliance Health Plan would facilitate doctor shopping and create additional disputes over medical treatment. Currently, roughly half the States are split between employee and employer choice of physician. Under title X, the employer would have no control and in some cases no input in that decision.

We believe that there is value to employer input into the choice of physician and that the employee is better served if he/she makes this decision with the advice of the employer. If the system allows the employee to switch doctors, this is likely to result in the unnecessary lengthening of the disability period and/or the impairment rating, which will increase costs.

The bill as substantially written reduces the ability of the employer to control treatment. This, coupled with the free choice of physician by the employee, could result in treatment by inappropriate provider or providers lacking appropriate training for the injury involved. In any case, it does nothing to enhance or maintain the quality of treatment available to the injured workers.

Case management: Case management is critical to the successful treatment of serious injuries. To speed recovery and allow a timely return to work for injured workers, the case manager needs a thorough understanding of the specific jobs and work place. This is most effectively accomplished by employer or carrier case managers. Case managers working for the alliances or AHP's (as structured under the Health Security Act) will be subject to internal financial pressures which are not conducive to the goal of high-quality, cost-effective care aimed at a prompt return to productivity. Additionally, dual case managers create further opportunity for additional strife within the system.

Cost Shifting: We are fearful that there are incentives in this bill for employees to shift cases to workers' compensation in order to receive first dollar coverage. While title X does contain language calling for the development of treatment protocols and fee schedules to address all medical services, until these are fully operational, health plans may still employ differential pricing to the detriment of workers' compensation.

Proposed Workers' Compensation Commission: The NAM questions whether Federal commissions produce value commensurate with their costs. In this case, we do not feel the commission should be charged with completing a study for further integration of the workers' compensation system into the general health care program before the reform program goes into effect. If the commission is required, it should not issue any recommendation until it has had time to evaluate the effectiveness of the reforms. In addition, we are concerned that the commission may expand its scope into issues concerning coverage and benefits, areas which fall under the jurisdiction of the States. The NAM believes these issues should remain with the States.

For the reasons listed above, the workers' compensation provisions of title X should be removed from the administration's Health Security Act. If a Federal health care reform plan is enacted, specific statutory language must be included to prohibit cost-shifting to workers' compensation.

This is a very difficult and complex issue to address. We do acknowledge that if the health care system undergoes comprehensive reform, the workers' compensation portion must be addressed as well. If not, the workers' compensation system will be doomed to cost-shifting.

We will review any health care reform proposal that includes workers' compensation in the overall context of the health care reform proposal. Until a plan is finalized, we believe the debate on health care reform must be resolved before it would be appropriate to legislate dramatic changes to the workers' compensation system. At this time, problems with the current system can best be resolved at the state level. Title X would create a new Federal regime for the workers' compensation system, prior to even understanding the new regime developed for health care.

The NAM and the AFL-CIO co-chair The Labor-Management Discussion Group on Workers' Compensation. We have been meeting for more than 2 years on a regular basis. Our primary focus has been on issues related to the two most important players in the system: the employee and the employer. We have developed white papers which our peers can use at the state level as a guide to solving some of their problems. We will continue to try, over the next few months, to do the same on this issue.

NAM members are concerned about their employees. We want to continue to provide them with affordable, high-quality health care. Many of the programs voluntarily provided by NAM companies provide the best protection available today at very competitive prices. We hope that the programs developed by the administration will allow us to continue to provide affordable, quality care for our employees.

Although some proposals currently under discussion are not necessarily what the NAM would suggest, we remain willing to explore the concept and trust that our words will carry weight in the legislative process. It should be noted that most of our business and industry associations are opposed to any Federal involvement with state workers' compensation programs.

Madam Chairwoman, thank you for the opportunity to address the subcommittee on this critical issue. I would be happy to answer any questions that you may have.

Mrs. COLLINS. You know, of course, that your entire testimony will be made a part of the record. I am looking at your testimony now. And on page 8, you are talking about choice of physicians, and in there you say that the proposal allowing States to certify specialists available to injured workers outside their basic alliance health plan would facilitate doctor shopping and create additional disputes over medical treatment.

Could you explain that in more detail to me, please?

Mr. STEGGERT. Yes, ma'am. Some of the States currently now have a semblance of medical control by either an employer or insurer by way of either State panels or State or governmental approval of such panels. In some jurisdictions, District of Columbia notably, it becomes a de facto free choice because they essentially certify any licensed health care provider which opens up the door to abuse and manipulation of the system by individuals trying to drive the indemnity side of the workers' compensation costs. And it does result in excessive and unwarranted medical treatment as well.

Mrs. COLLINS. And you say that under title IX the employer wouldn't have any control and in some cases no input at all in that kind of decision?

Mr. STEGGERT. Under title X, yes, ma'am.

Mrs. COLLINS. Under title X. Did I say nine?

Mr. STEGGERT. Yes, ma'am.

Mrs. COLLINS. I have been working on title IX so much in other bills, it was a slip, I am sorry.

Mr. STEGGERT. That is quite all right. I just don't want to be misquoted.

Mrs. COLLINS. Do you think that employers and workers' compensation insurers have any incentive to find doctors that are going to return workers to work sooner than it is appropriate?

Mr. STEGGERT. I have heard organized labor express some concerns about employer concern over doctors. And, in fact, we discussed that in the labor management discussion group with NAM, cochaired with the AFL-CIO. That is a valid concern in some areas. However, the majority of employers and insurers, since they are paying the entire cost of the workers' compensation bill, if you will, not just the 40 percent of medical, are more geared towards quality providers that make a timely diagnosis, aggressive treatment plan, and ultimately return people to work as soon as possible.

Empirically, I am not sure that has been demonstrated to benefit the injured worker. But experience does tell us that injured workers who get back in the mainstream of employment quicker have quicker emotional healing as well as physical healing and we do

think it is in the interest of the business community to get people back to work as soon as it is practicable.

Mrs. COLLINS. Ms. Ballen, some employers and insurance organizations have been arguing that workers' compensation insurance should be completely left out of the health care reform? Do you agree with that?

Ms. BALLEEN. We have cost shifting concerns if that happens. Some of the issues that were raised in the testimonies of all of the witnesses, particularly if the overall health plan is one that results in a lot of different regulatory controls and price controls, there could be an incentive and perhaps an opportunity for doctors to raise prices for workers' compensation patients.

In order to fully answer the question, you really need to look at the details of whatever the rest of the plan looks like. We have only begun to analyze the Clinton plan as it now exists and my guess is it is going to change quite a bit, so we will need more analysis of that particular point.

Mrs. COLLINS. According to your testimony, Mr. Steggert, NAM is one of the organizations that believes title X ought to be dropped; is that right?

Mr. STEGGERT. NAM believed the title X should be dropped; yes, ma'am.

Mrs. COLLINS. Why?

Mr. STEGGERT. For a number of reasons. We don't think that it benefits the workers' compensation community and the injured employees. We think it would drive up costs ultimately by allowing or, excuse me, not allowing the employer to be involved in the selection of specialists, involved in occupational medicine.

My company operates in 50 States so theoretically we would be dealing with the universe of health care providers as opposed to providers who we know are specialists in occupational medicine, understand our particular industry, and work with our case managers, nurses, regularly, in an effort to minimize both the overall cost and not just necessarily medical cost, but to get the best outcome and lowest feasible departure from work for the cost of the system.

Again, it is only 40 percent of the workers' compensation pie, and we think that other 60 percent deserves separate attention outside of the Health Security Act.

Mrs. COLLINS. Mr. Taylor, where do you stand on title X?

Mr. TAYLOR. We feel that it should be coordinated and we feel that some of the issues that must be clearly addressed from a claims administration standpoint is that claims control is vital to an automobile insurer. We need to be part of the medical process. We have to be able to monitor medical treatment and be able to take timely steps to mitigate damages claimed. And that involves early investigative measures.

Unfortunately, we heard Mr. Steggert talk about insurance fraud earlier. That also exists with regard to auto insurance, not only workers' compensation. Unfortunately, some individuals view being involved in an auto accident as a financial bonanza. One of our fears is that risk-free and easy access to a health care system without diligent case management and careful utilization review would

likely help fuel litigation through claims buildup. And that would add to an already heavily burdened court system, in our opinion.

Mrs. COLLINS. Thank you.

Mr. Stearns.

Mr. STEARNS. Thank you, Madam Chairwoman.

Ms. Ballen, do you think that a merger of workmen's compensation medical care into a national health care system would result in administrative savings and efficiencies? Or would it add new costs?

Ms. BALLEEN. We think it would clearly add new costs. The proposed savings that have been suggested by some of the proponents come in the area of things like you don't have to determine whether a claim is work-related or not. In fact, as long as the workers' compensation system provides a different package of benefits, including the wage loss benefits that it provides that aren't provided by health care, health insurance, as well as a richer benefit package of medical, you are still going to have those same determinations. So the basic administrative savings that have been suggested by some won't materialize. Costs will rise in two material respects, both of which have been talked about earlier.

First of all, there is the safety problem. By reducing safety incentives, you are likely to have more injuries and every injury that gets processed through the workers' compensation system costs a lot of money. Second of all, if medical treatment is provided by a health plan that is not sensitive to the need to timely return to work, the wage loss component will go up and we think that increased costs for the wage loss component will more than offset any possible savings that could materialize on the medical side.

Mr. STEARNS. What do you think of the discussion we had with Mr. Claxton concerning implementing regulations? Did you hear any of that suggestion?

Ms. BALLEEN. I did. I was interested in his views as to how easy it could be. I guess we don't share that view. There are right now State agencies in every State that are tasked with workers' compensation implementation regulations. I know from, I wouldn't say personal experience, but general observation, when Texas, for example, enacted major system reforms in the early 1990s, it took several years for them to figure out the details in terms of implementing regulations just for a relatively modest set of changes that applied to one State.

So whether DOL has to do it or he said rather simply that, gee, the States will have to make certain changes to their workers' compensation systems to comply, that is really a monumental task and you do run the risk of having a lot of people just sort of left out in the lurch while that is ongoing.

Mr. STEARNS. You think you could extrapolate 2 years for Texas, 100 years for the United States?

Ms. BALLEEN. Sounds good.

Mr. STEARNS. This is for all the panelists. Assuming Federal reg—excuse me. Assuming Federal legislation applies to the medical portion of automobile insurance, do you favor a, quote "coordination system that leaves the ultimate financing of auto accident-related health care with the auto insurance system" or a "merger

system" in which the health care system assumes the burden of financing auto accident-related medical care? And why?

Mr. TAYLOR. If I may answer that question, speaking on behalf of the Alliance of American Insurers and Amica Mutual Insurance Company as well, we favor coordination. I think it should be observed that approximately 20 to 25 percent of our total auto premium base would be absorbed by an integration into the Federal health care system.

In Amica's case, we had a \$602 million premium base in 1993 for automobile insurance. That would represent lost premium to my company of somewhere between 120 and 150 million dollars per year. Compounded by the number of automobile insurers which exist in the United States, I think the economic dislocation in terms of the financial impact on insurers, the independent agents, including the mom and pop operations of one, two or three or four people, and the jobs lost, would be staggering.

I think primacy of auto should be such that case management should be left in the hands of auto insurers who have a direct financial interest in the outcome. However, through coordination, we could clearly avoid cost shifting of expenses to the casualty insurer industry.

Ms. BALLEEN. Do you want us all to answer that?

Mr. STEARNS. Sure, Ms. Ballen, then Mr. Steggert.

Ms. BALLEEN. Like Mr. Taylor, we strongly favor coordination. We oppose merger. Let me just add one more point that needs to be considered for the auto context when you think about a merger, and that is the financing issue.

Someone asked Mr. Claxton about that. It might have been you, Mr. Stearns. Generally, for automobile insurance, there is about \$14 billion of medical-related costs that are now financed through the automobile insurance system. To transfer that over to the health insurance system, first of all, raises a question about who pays.

I mean right now there is an 80/20 split between employers and employees. Automobile insurance is considered, I think, an individual responsibility right now. Is that going to be translated into an employer mandate if the costs are shifted into the employer mandate? And just how are you going to raise the money if not by generally adding to the premiums?

Mr. STEARNS. Mr. Steggert.

Mr. STEGGERT. NAM's risk management committee and subcommittee on workers' compensation didn't go into detail in the auto segment of title X, but we would generally favor coordination over merger for the reasons expressed here.

Mr. STEARNS. Thank you, Madam Chairwoman.

Mrs. COLLINS. Mr. Steggert, the insurance industry has argued that experience rating for workers' compensation, that is, charging higher premiums to employers in high risk industries or with bad records, is a valuable tool for encouraging employers to maintain safe workplaces. Do you agree with that?

Mr. STEGGERT. Absolutely. And I might add, I am not testifying today on behalf of the National Council of Self-Insurers, but I am an executive officer of that organization. And roughly 30 or 35 percent of the businesses in this country do self-insure their workers'

compensation exposure, which means paying it from dollar one without getting into any excess coverage, which generally doesn't kick in until either a hundred thousand, a half million or sometimes millions of dollars.

It is obviously a direct incentive on the bottom line of corporate America and is very significant in terms of prevention activities, as well as after the injury, case management activities, and it does promote aggressive intervention, ultimately cost containment, and it benefits our society greatly, we believe.

Mrs. COLLINS. Ms. Ballen, do you think that experience rating in workers' compensation insurance has any effect on the employer behavior?

Ms. BALLEEN. Sure. As Mr. Steggert indicated, it provides a definite incentive for employers to make the investment in safe workplaces, to provide safety training. We think the most effective safety initiatives that can be brought into the workplace are those that provide a financial incentive for employers, and workers' compensation experience rating is certainly one such thing.

Mrs. COLLINS. What about automobile insurance, does experience rating have an effect on driver behavior, Mr. Taylor?

Mr. TAYLOR. I think it has a dramatic effect. I think integration of auto insurance into a Federal health care system would diminish incentives for safe driving. There would be no accountability. Reckless drivers would simply dump the cost of their irresponsibility on to the system. Therefore, we favor maintaining auto primacy.

Mrs. COLLINS. When we talk with various groups of people who come in to talk about this particular issue, there is always differences of opinion. And one question that has arisen over and over again is whether the employer should have control over the choice of physician. And it has been suggested to the subcommittee that title X be amended to give employers more control over the choice of physician and case management.

And the question is for either of you or all of you, would you be willing to support that or do you think it is necessary? Your thoughts, why don't we start with you, Mr. Steggert. Go right down the line.

Mr. STEGGERT. Again, repeating that we want—don't support title X in the Health Security Act generally, to address if there were comprehensive reform, certainly more employer control, and I use employer and insurer interchangeably in that circumstance, needs to be built into the act.

Mrs. COLLINS. Although the NAM, I take it, I understand that NAM opposes any federalization of worker compensation programs; is that right?

Mr. STEGGERT. Yes, ma'am.

Mrs. COLLINS. OK. Mr. Taylor.

Mr. TAYLOR. I think selection of a medical care provider is less of a concern to us in the auto insurance industry as is the case of cost shifting. We feel as though we should be on a level playing field paying the same fee for a broken arm, whether it is Medicaid, workers' compensation or auto casualty.

Ms. BALLEEN. Back to workers' compensation, we definitely think that there is a need for more employer and insurer involvement in the choice of physician than is provided by title X. Recognizing that

right now every State has various consumer safeguards to assure that in the event of any kind of dispute, those things are worked out at the State level. So it is not simply a question of giving the employer 100 percent of control over it. It is an initial choice that is made.

If things go well, as we hope they will, there is no need for any kind of regulatory involvement, but the safeguards are there in the event of a dispute and we think that can work well with the existing State system, changing title X.

Mrs. COLLINS. Both you and Mr. Taylor have raised the question of how fees for medical care should be set. It seems to me that the cost of taking care of a broken leg shouldn't change just because someone broke it at work instead of on a ski slope. Would you agree with that?

Ms. BALLEEN. For the most part. Sometimes there are legitimate reasons to have a difference. In a workers' compensation context, for example, you may decide that a special cast that enables a worker to get back to work more quickly is a worthwhile investment and that ought to be permitted where it makes sense.

Mrs. COLLINS. Would you agree with that, Mr. Taylor?

Mr. TAYLOR. I can't think of any example where I would feel personally that it should make any difference to have a separate set of fees for one body over another, not at all.

Mrs. COLLINS. Well, now H.R. 3600 currently requires each State to develop a fee schedule to cover health care services provided by fee-for-service plans. Would you be willing to have that schedule apply to workers' compensation services? Either of you? Anybody?

Ms. BALLEEN. We would be. The problem with the bill, as it is now drafted, is that the States or the original alliances can decide not to use those fee schedules and to use anything else they want for workers' compensation. We agree with the principle, but it is not exactly drafted in a way that really makes sure that will happen.

Mrs. COLLINS. So you would say that worker compensation insurers ought to be allowed to bargain better prices if they can? Would you think that would be a good thing?

Ms. BALLEEN. They certainly should be allowed to do that, or use the best of the best practitioners who may have more expensive rates, but it makes sense in light of the quality of the care that they can provide.

Mrs. COLLINS. Thank you.

Mr. Stearns.

Mr. STEARNS. Thank you, Madam Chairwoman. Here is a question that sort of intrigued me when I first heard Mrs. Clinton say that she was going to fold workers' compensation into the health care bill.

Do automobile insurers make substantial payments of medical expenses that are already covered by health or other automobile insurance? If so, at a time when millions of Americans have either inadequate insurance or none at all, shouldn't we be looking for ways to eliminate such duplicate payments? This is for all panelists.

Mr. TAYLOR. Yes, that is clearly one of my strongest points here this morning, is duplicate payments should not exist. We are clearly opposed to duplicate payments. We think that it adds tremen-

dous cost to the system and to the extent we can rid the system of that burden, the better the system will be.

Mr. STEARNS. Ms. Ballen.

Ms. BALLEEN. We agreed that it is extremely important to eliminate duplicate payments and would suggest that we ought to be the ones that are making the payments. Relieve the health insurance system of the medical costs associated with automobile accidents. Make sure that the property casualty insurer pays for it. And that is a way to save costs in health insurance.

Mr. STENHOLM. Mr. Steggert.

Mr. STEGGERT. We fully agree, there should be no duplicate payments. A number of the States have tried to address that in the workers' compensation and no-fault section by designating which is primary to allow an offset. However, little discussed occasionally is when plaintiff attorneys make demands for medical payments under certain liability policies. Those are payable many times irrespective of outside coverage. So you are in essence paying it directly to the injured worker and then paying the bill directly in another form, so that should be eliminated.

Mr. STEARNS. Tell me, Mr. Steggert, in greater detail why you believe it is important for the employer insurance carrier to have early intervention oversight in the treatment of work-related injuries? Is this important for self-insured employers and insurance companies?

Mr. STEGGERT. It is in both—it is important to both self-insurers and insurance companies. It is important because both those providers are people in a superior position to identify the highest quality organizations or physicians experienced in occupational health and medicine and can steer appropriate injuries to those providers for prompt and proper diagnosis and aggressive treatment plan in cooperation with case managers aimed at early return to work at the optimum time to minimize the overall cost of the workers' compensation case. And when I say that, I am not talking about minimizing the medical component.

In many circumstances employers and insurers pay more for aggressive medical treatment in order to minimize the overall cost of the injury impairment and residual disability as well as the duration away from the work force. So it is in their best interests since they are paying 100 percent of the cost either as a self-insurer or through an insurance premium to minimize that cost.

Mr. STEARNS. How does Marriott go about ensuring that work-related injuries receive quick and quality medical treatment?

Mr. STEGGERT. We personally have got a network of 13 occupational health nurses who assist us directly in our cases. They intervene within 24 hours of every injury case, identify the appropriate primary treating physician, communicate with the injured worker, the supervisor, the unit where the location occurs, and the physician, in order to make, as I said earlier, a prompt diagnosis and treatment. They also establish dialogue aimed at an early return to work, and ultimately successfully bring that person back to work.

I also might add that is a strategic step in order to avoid friction, costs and litigation. Injuries can be contentious in today's environment of significant attorney advertisement and the more people sit

at home and watch soap operas and ads every 30 seconds on TV, it really interferes with the good intentions of employers wanting to bring people back to legitimate wage-earning jobs.

Mr. STEARNS. You know, you always hear the argument, it is good for the employer to get them back to work, but I think there is also an argument that it is good for the employee, too.

Mr. STEGGERT. Absolutely, we agree with that entirely. And, in fact, internally our nurses have been trained in post traumatic stress disorder intervention and try to deal with employees dealing with not only the physical aspect of their injury, but the emotional side of the injury. And people that understand occupational medicine and injuries understand that importance of direct dealing with their injured workers, making certain they understand they are valued, want them to come back to work, and really don't want any unnecessary adversaries in the system. They generally want to pay the medical bills associated with the injury, the rehabilitation and bring people back to work and pay them the impairment rating they are entitled to if they have an amputated finger, something of that nature.

Mr. STEARNS. Mr. Taylor? Ms. Ballen, any other comment?

Mr. TAYLOR. I would like to make one quick comment, if I may. I will make it quick. I think direct early involvement of a casualty insurer in the medical process is vital. And I say that because medical damages are a key element to the ultimate settlement value of a claim. Therefore, as soon as a liability situation arises, as soon as a claim is reported, it is of paramount importance that an insurance company set aside an adequate amount of money, we call those reserves, individual case reserves, to meet our future settlement obligation on that claim.

If we are unable to get adequate information or receive scant information, underreserving could take place. That creates the possibility for insolvency. Insolvency puts a burden on State guarantee funds and no one wins. People are left without remedy. State guarantee funds are depleted. So I think seriously, we must consider having auto medical coordinated with the health care system from a reserving standpoint or we are going to run the risk of some financial disaster here.

Ms. BALLEEN. I would echo the need for early intervention, both in terms of the claims management process and, of course, the insurer solvency. In this regard, one of our member companies, Travelers, recently published an article about their own successes in terms of implementing an early intervention program and we would be glad to provide a copy of that to the subcommittee if you are interested.

Mr. STEARNS. Yes, we would like that. That would be good. Thank you, Madam Chairwoman.

Mrs. COLLINS. Thank you very much. Let me say to all of the witnesses, where you have been asked to submit additional testimony in writing or questions to be answered, they should be answered within 5 legislative days because we are on a very strict timetable with this piece of legislation, as has already been reported in the newspapers and et cetera.

With that, I would say thank you to all of our witnesses, and to our last panel for the information you have provided this subcommittee. This hearing is adjourned.

[Whereupon, at 12:20 p.m., the subcommittee adjourned, to reconvene at the call of the Chair.]

[The following material was received for the record:]

naib NATIONAL ASSOCIATION OF INSURANCE BROKERS

1401 New York Avenue, N.W. • Suite 720 • Washington, D.C. 20005 • Phone (202) 628-6700 • Fax (202) 628-6707

January 31, 1994

The Honorable Cardiss Collins
 Chairwoman
 The Subcommittee on Commerce, Consumer
 Protection and Competitiveness
 U.S. House of Representatives
 Washington, DC 20515

RE: Comments for the February 1, 1994, Hearing Record
 On Title X of the Health Security Act, HR 3600

Dear Madam Chairwoman:

The National Association of Insurance Brokers is the trade association of commercial insurance brokers, and our members range in size from large international companies to regional and local firms that provide insurance and risk management services to businesses in the United States and around the world. NAIB members administer the majority of the coverage in the commercial property-casualty insurance marketplace in the United States.

As experts in the insurance marketplace with indepth knowledge of the options that businesses have to meet their obligations to employees to provide medical treatment and wage indemnification to injured employees under workers compensation laws, the NAIB has reviewed Title X of the Health Security Act. We have grave concerns about the impact of the legislation on both employers and the insurance marketplace, and we offer the following suggestions for the consideration of your subcommittee.

ISSUE BACKGROUND:

HR 3600 would require delivery of health care services to injured workers through the new universal health care system. Workers compensation insurers would continue to collect a premium from employers which would be used to reimburse the health providers for medical care and also pay injured workers for lost wages. If an employer self-insures workers compensation coverage, the employer pays all medical costs and covers lost wages directly. Other health reform proposals pending in the Congress do not address the question of coordinating workers compensation coverage with general health care coverage.

NAIB Comments on
Title X of HR 3600
Page, 2

CURRENT WORKERS COMPENSATION SYSTEM:

The workers compensation system, developed more than 80 years ago and administered by the states, provides comprehensive medical benefits to workers with work-related injuries and illnesses. It is a no-fault system in which workers receive prompt access to medical care, long-term benefits, and wage replacement in exchange for agreeing that workers compensation coverage will be their exclusive remedy against an employer for work-related injuries.

According to AM Best, workers compensation medical costs are approximately \$30 billion annually, representing an estimated 3 percent of all health care costs in the United States.

There is a critical linkage between delivery of health services under workers compensation and the cost of the system. Because employers have an obligation to pay wages to injured workers, there is an incentive to provide employees with good occupational treatment that will return the employee to the workplace in a timely manner. Without coordination of individual injury treatment and timely return of the employee to work, costs quickly escalate.

The workers compensation system encountered some costly problems during the 1980s with the rapid increase in medical costs, which now account for more than 40 percent of workers compensation costs, up from 30 percent just 10 years ago. Many states have been successful in implementing cost containment reforms, such as managed care and fee schedules, and, in 1993, at least 12 states are expected to see substantial savings in workers compensation costs as a result of cost containment reforms. In many states, employers are experimenting with new workers compensation systems, such as the one Oregon has adopted to provide a system of 24-hour health coverage.

PROBLEMS WITH PROPOSED CLINTON PLAN CHANGES:

Employers and their commercial insurance brokers and underwriters are concerned that the Clinton plan risks major cost escalations in workers compensation rates, because the link between medical care and wage replacement for injured workers is severed. The cost of replacing a worker's wages will increase significantly if expert occupational medical treatment is not delivered immediately to the injured worker by a provider that is experienced in treating injured workers.

The key factor in an efficient workers compensation system is delivering appropriate care that will return an employee to the workplace in a timely manner. Delays, caused either by medical care that is inappropriate to an occupational injury or is not provided as quickly as possible, will result in longer absences from the workplace. Costs to employers escalate accordingly. For instance, the Alliance of American Insurers estimates that if one day is added to each disability claim, another \$10.6 billion in costs is added to the workers compensation system.

PROPOSAL TO COORDINATE WORKERS COMPENSATION AND GENERAL HEALTH CARE:

The NAIB proposes to amend the Clinton health plan to give employers/carriers the choice of the medical care provider for work-related injuries and illnesses from among state-certified specialized workers compensation providers authorized in Title X of the legislation, which may include AHPs.

This solution maintains the link between providing medical care and payment for lost wages in conjunction with the health care infrastructure being developed under the legislation. It will ensure that injured workers receive expert occupational medical care and timely return to the workplace, basic tenets of the no-fault workers compensation system. In addition, health plans will be encouraged to compete with one another for this business, an incentive to provide workers compensation services at a competitive price.

This approach ensures that the parties who are financially responsible play a role in managing the medical care and rehabilitation program. Employees would be free to choose their physician or medical provider within the workers compensation medical plan, and it is in the employers' best interest that workers receive the best treatment, therapy and rehabilitation services to enable timely return to the workplace. Currently, 22 jurisdictions permit employers to choose the workers compensation medical provider, and, in a majority of all states, there are restrictions placed on choices by both employees and employers to enable the financially responsible party to manage the case costs. All states have workers compensation administrative agencies that can ultimately control the case.

The NAIB proposal further implements the proven benefits of a managed care system for work-related injuries and illnesses, maintains the important connection between the employer payment of medical costs and lost wages, ensures the delivery of expert treatment of workplace injuries, and preserves the workplace safety incentives of the current system.

Thank you for considering our views. We look forward to working with you, members of your subcommittee, and the subcommittee staff as you review this issue.

Sincerely,



Thomas A. Clarke, Chairman
Workers Compensation Committee

February 1994

**STATEMENT OF STATE FARM MUTUAL AUTOMOBILE INSURANCE
COMPANY ON THE AUTOMOBILE INSURANCE PROVISIONS OF
TITLE X OF THE HEALTH SECURITY ACT (H.R. 3600)**

State Farm Mutual Automobile Insurance Company appreciates the opportunity to submit its views to the Subcommittee on the automobile insurance coordination provisions in Title X of The Clinton Administration's Health Security Act (H.R. 3600). As the largest automobile insurer in the nation, insuring more than 35 million automobiles, State Farm has a major stake in reforms affecting the medical component of automobile insurance.

Title X of the Health Security Act would directly alter the current mechanisms for delivery of health care covered by automobile insurance through a new "coordinated" system. State Farm supports the basic principles underlying the Title X automobile insurance coordination plan, but believes certain modifications to and clarifications of the Title X language are necessary to ensure that it serves the Act's fundamental goals of efficient and effective health care delivery and medical cost management.

**A. Background: Health Care Paid
By Automobile Insurance**

The automobile insurance system currently finances health care for injuries sustained in automobile accidents in two principal ways: (1) direct payment to an injured individual under such individual's automobile insurance policy, and (2) indirect payment to an injured individual under the insurance policy of another person legally responsible for causing the accident in which the injuries were sustained. The total industry costs covered by both types of payments amount to approximately \$12.5 billion per year.

As Congress well knows, the costs of health care have rapidly escalated. Problems specific to the automobile medical insurance system, however, are fueling cost increases for auto accident-related health care that go beyond the general cost-escalation trend. Principal among these problems are duplicate payments for auto accident-related health care, unwarranted expenditures on such care, and shifting of general health care costs to automobile insurers. Health care reform legislation that fails to address these problems could seriously exacerbate their cost-inflationary effects.

1. Duplicate Payments

Duplicate payments for auto accident-related health care are prevalent. According to current estimates, duplicate payments for such care amount to approximately \$5 billion per year. This represents about 40 percent of the total of \$12.5 billion of health care costs annually paid by automobile insurers.

Some duplicate payments for auto accident-related health care occur because of overlapping health and auto insurance coverages held by a single individual. Even more, however, are the result of laws applied in auto accident liability cases that permit an injured individual to recover from the driver responsible for the accident (i.e., the driver's automobile liability insurer) the costs of medical care already paid for by insurance. In some instances, the existence of both overlapping health and automobile medical insurance and the ability to recover medical expenses through automobile liability insurance results in three separate payments for a single medical expense.

When 37 million Americans have no health insurance coverage at all, it seems unthinkable to allow such duplicative payments. Any responsible plan for health care reform should include provisions to ensure that there is only single payment for medical expenses; this is at the heart of the "coordination" goal.

2. Artificial Cost Inflation

Under the current automobile insurance system, there is no effective way for automobile insurers to manage the extent and cost of health care provided for most automobile accident-related injuries. Because most automobile insurance health care payments are made under liability policies for treatment of persons other than the insured, automobile insurers are not in a position to manage the types and extent of treatment they pay for. Unlike health maintenance organizations and preferred-provider network insurers, automobile insurers -- whose payments for health care are almost always on a fee-for-service basis -- generally cannot, for example, require that the medical treatment they cover under liability policies be subject to utilization review or specific fee limits. As a result, automobile insurers have little ability to ensure that the costs charged for auto accident-related medical care are reasonable or that the services provided were medically appropriate.

The lack of cost management for auto accident-related medical services creates perverse incentives for over-utilization of such services. In some cases, these incentives lead to abuse and even fraud. Any health care reform legislation that aims to curb health care costs overall should include measures to eradicate these incentives and their adverse results.

3. Cost Shifting

Closely related to the problem of uncontrolled automobile accident-related health care expenditures is the problem of cost shifting. To some extent, all private insurers of medical care are the victims of cost shifting, as providers seek to compensate for government caps on reimbursement under Medicare and Medicaid. The problem is particularly acute for automobile insurers.

Health care reform legislation has the potential to create a more equitable and rational system by applying uniform cost management techniques to medical care covered by all types of insurance, including automobile insurance. This is the approach of the Health Security Act: under Title X, the fee schedules to be established under the Act would apply to automobile accident-related health care as they do to other types of health care. State Farm strongly supports this aspect of the Act, which reflects recognition that if cost controls, such as fee schedules, do not apply uniformly to health care for

injuries caused by auto accidents and injuries otherwise sustained, cost shifting to automobile insurers will amplify, rather than eliminate, existing cost-allocation distortions.

B. The Title X Coordination Plan

Title X prescribes a system for coordinating automobile medical insurance with the proposed new health care system. Specifically, Subtitle B of Title X provides that (1) an individual injured in an automobile accident shall receive treatment for the injury by or through such individual's health plan and (2) automobile insurers responsible for payment of medical expenses shall make such payments directly to the health plan.

The basic elements of the Subtitle B coordination plan are sound. They would retain the benefits of the current system of financing auto accident-related health care through automobile insurance -- internalizing the costs of auto accidents and thereby encouraging auto safety -- while providing a mechanism for more efficient delivery of and payment for such care. If appropriately implemented, the Subtitle B plan could represent a vast improvement over the current system.

Subtitle B fails, however, adequately to address certain of the problems cited above, including the problem of duplicate payments. The Health Security Act expresses a general intent to eliminate duplicate medical insurance payments (see, e.g., sections 1422(a) and 2324(f)), but Title X contains no provisions to carry out this intent with respect to payments for automobile accident-related health care. State Farm believes that the inclusion of such provisions is critical.

To address the duplicate payments problem, Subtitle B should be amended to state that, notwithstanding current liability rules, there shall be no payment for auto accident-related health care expenditures except to the health plans and in accordance with the Act's coordination scheme. This amendment would ensure that the health plans, and only the health plans, receive payment for the auto accident-related medical services they provide. Absent such amending language, Subtitle B will merely perpetuate inequity in the health care insurance reimbursement system.

In order to address the cost management problems discussed above, further amendments should be made to the current Subtitle B language. Specifically, there should be provisions that expressly extend to auto accident-related medical care the Act's general requirements that medical services provided by health plans be (i) limited to "medically necessary or appropriate" services (Section 1141(a)) and (ii) subject to "reasonable restrictions" (as described in Section 1322(b)(2)(B)). Such provisions, coupled with the existing Subtitle B language regarding application of the Act's medical services fee schedules to auto accident-related services, would represent very substantial steps toward management of auto accident-related health care costs.

C. The Subtitle C Commission

Subtitle C of Title X calls for a Commission on Integration of Health Benefits, to be charged with studying the feasibility and appropriateness of transferring financial responsibility for all medical benefits, including those currently covered under workers' compensation and automobile insurance, to health plans. State Farm believes that there is no need for such a study, because there is ample evidence that financial "merger" of automobile insurance with the health care system would be unwise.

Financing auto accident-related health care through the automobile insurance system has sound public policy justifications. First, it is fair: it avoids imposing auto accident-related costs on persons who do not contribute to those costs (i.e., non-drivers). Second, it makes drivers accountable for the risks they pose, and thereby encourages safer driving. Finally, it provides incentives for automobile insurers to promote increased auto and highway safety -- incentives that have proved highly instrumental in advancing new highway and auto safety legislation, regulations, and other initiatives. Given the importance of preventive mechanisms for reducing health care costs and the substantial financial burdens the government must assume to improve other aspects of the health care system, it would seem futile, at best, to consider whether automobile medical insurance should be "merged" with the health care system.

Accordingly, State Farm would suggest that the proposed commission not study -- or at least not exclusively study -- the possibility of transferring financial responsibility for auto accident-related health care to the health plans. State Farm believes that if there is to be a study, it should broadly address possible ways of improving the delivery of and payment for auto accident-related medical services.

State Farm also firmly believes that no commission should be charged with studying both automobile insurance and workers' compensation insurance. There are significant ways in which automobile insurance differs from workers' compensation insurance, which counsels against any commingling of decision making with respect to each system. Recognition of these differences should be made both in considering the role of the proposed Subtitle C commission and the benefits of the auto insurance coordination provisions of Subtitle B, as opposed to the workers' compensation provisions of Subtitle A.

With respect to workers' compensation, there are important questions relating to the employer's responsibility for the course of treatment for disabled workers under workers' compensation that are not relevant in the automobile insurance context. For example, the extent to which employers should control the type and extent of care provided under workers' compensation insurance, and the role of state and or federal regulators in monitoring such control, are critical issues with respect to possible reform of the workers' compensation system, but they have little bearing on the automobile insurance system.

Likewise, there are questions about automobile insurance that have no corollary in the workers' compensation context. Most obviously, issues relating to automobile liability insurance are not relevant to workers' compensation. Critical questions, such as how to remove impediments to efficient resolution of automobile liability insurance claims, should be addressed when considering automobile medical insurance reforms, but need not be addressed with respect to workers' compensation reforms.

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Accordingly, State Farm would suggest that, if there is to be a commission charged with studying automobile medical insurance, it have no responsibilities relating to workers' compensation insurance. Consonant with this suggestion, State Farm believes that the members of any such automobile insurance commission should not be appointed by the Secretary of Health and Human Services and the Secretary of Labor, as Subtitle C currently provides, but rather by the Secretary of Health and Human Services and the Secretary of Commerce.

Finally, State Farm believes that any Subtitle C commission should have more time to complete its study, in order that it have an opportunity to evaluate the experience of the new Subtitle B coordinated system before recommending any changes to it. State Farm would suggest that the deadline for submission of the commission's report to the President should be postponed until two years after the effective date of Subtitle B.

* * *

In summary, State Farm strongly supports adoption of a properly coordinated automobile medical insurance system, under which drivers would remain accountable for the health care costs associated with auto accidents. Such a system could result in a more rational health care delivery system with increased efficiencies, including the elimination of duplicate auto accident-related medical payments and uniform management of auto accident-related and other health care expenditures. These efficiencies, in turn, can help to make health care and automobile insurance more affordable for all Americans. State Farm believes that, with appropriate amendments, Title X of the Health Security Act has the potential to achieve these important goals.

January 1994

SUBMITTED BY STATE FARM INSURANCE COMPANY

COORDINATING AUTOMOBILE MEDICAL INSURANCE
WITH A NEW NATIONAL HEALTH CARE SYSTEM

The Clinton Administration's proposed Health Security Act (the "Act") includes a plan for coordinating the medical component of automobile insurance with a reformed health care system. State Farm Mutual Automobile Insurance Company agrees with the principles underlying the Act's auto insurance coordination plan but believes that certain clarifying provisions are necessary to ensure that the benefits of the plan are fully realized.

Automobile insurance coordination, if implemented appropriately, would significantly reduce the cost of auto accident-related health care. First, it would eliminate duplicate payments for such health care, which currently are prevalent. Second, it would involve the application of the same cost controls to health care for auto accident-related injuries as are prescribed for health care for other types of injuries or illnesses, thereby preventing the artificial inflation of charges for auto accident-related medical services.

Duplicate payments for auto accident-related health care are a serious problem. According to current estimates, duplicate payments for such care amount to approximately \$5 billion per year. This represents about 40 percent of the total of \$12.5 billion of health care costs annually paid by automobile insurers -- about 3 percent of the \$165 billion of total national health care payments per year.

Some duplicate payments for auto accident-related health care occur because of overlapping health and auto insurance coverages held by a single individual. Even more, however, are the result of laws applied in auto accident liability cases that permit an injured individual to recover from the driver responsible for the accident (i.e., the driver's automobile liability insurer) the costs of medical care already paid for by insurance. When 37 million Americans have no health insurance coverage at all, it seems unthinkable to allow such duplicate payments for medical expenses.

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Title X of the Health Security Act has the potential to eliminate duplicate payments for auto-related medical care. It requires that (1) an individual injured in an automobile accident receive treatment for the injury by or through such individual's health plan and (2) automobile insurers responsible for payment of medical expenses make such payments directly to the health plan.

Title X does not expressly prescribe, however, specific rules regarding payments by automobile liability insurers to the health plans. Under current law, recovering from a liability insurer can take months or even years, in order to resolve issues of fault and damages. To efficiently implement the payment obligations of automobile insurance carriers, Title X should be amended to require the states to establish systems for resolving automobile accident liability and payment issues without the delay and cost of litigation. In addition, to effectuate the Act's general intent to eliminate duplicate medical insurance payments (see, e.g., sections 1422(a) and 2324(f)), Title X should be amended expressly to state that, notwithstanding current liability rules, awards to an individual injured in an automobile accident shall not include payment for medical treatment provided by a health plan. This would ensure that the health plans, and only the health plans, receive payment for the auto accident-related medical services they provide.

Title X also has the potential to reduce the costs of auto accident-related health care by applying the same costs controls to such care as the Act applies to health care generally. Title X currently states that the medical services fee schedule applicable generally under the Act shall apply similarly in the auto accident-related health care context. Title X would ensure additional cost containment if it were amended to state expressly that the Act's general requirement that health plans provide only "medically necessary and appropriate" services is similarly applicable in the Title X context.

In addition, Title X should be clarified to avoid confusion regarding the principles applicable to coordination of automobile insurance and the considerations relevant to coordination of workers' compensation insurance. Subtitle C of Title X calls for the establishment of a commission to study "integration" of both types of insurance with the health care system. Because of the significant differences between automobile and workers' compensation insurance, however, it would seem more appropriate to create a separate commission to study automobile insurance, the members of which could be appointed by the Secretary of Commerce (jointly with the Secretary of Health and Human Services), rather than by the Secretary of Labor, as Title X currently provides.

State Farm firmly believes that a coordinated automobile medical insurance system, under which drivers would remain accountable for the health care costs associated with auto accidents, could result in a more rational health care delivery system with increased efficiencies. These efficiencies, including the elimination of duplicate auto accident-related medical payments and uniform management of auto accident-related and other health care expenditures, can help to make health care and automobile insurance more affordable for all Americans.

January 1994

STATE FARM PRINCIPLES FOR AUTOMOBILE
ACCIDENT-RELATED HEALTH INSURANCE REFORM

1. Coordination of Auto and Health Insurance Systems. Comprehensive reform of the nation's health care system should provide for coordination of the medical portion of automobile insurance with the new health care system. Such coordination is critical to efficient and effective payments for auto accident-related health care expenses.
2. Elimination of Duplicate Payments. The existing automobile insurance system incurs large, unnecessary costs from duplicate payments for health care expenses. Duplicate payments for auto accident-related health care expenses are estimated at about \$5 billion per year, or about 40 percent of the total \$12.5 billion of health care costs annually paid by automobile insurers. Properly designed auto insurance coordination would eliminate duplicate payments.
3. Exclusive Recovery of Health Care Costs. Federal health care legislation should provide that payments for auto accident-related medical services within the scope of the "basic benefits" guaranteed by the health care system are to be made exclusively to the health care system, thereby preventing duplicate payments while leaving injured parties free to pursue tort claims for other related damages, such as lost wages and noneconomic losses.
4. Curtailment of Fraud and Abuse. Fraud and abuse in connection with claims for health care insurance contribute significantly to the high costs of the nation's health care. Modification of the rules regarding payment of automobile insurance for health care expenses in order to prevent duplicate payments will help remove improper incentives for overutilization of health care services. There must also be effective sanctions to penalize fraud and abuse relating to insurance claims.

5. Consistent Treatment of Auto-Related Medical Expenses. Health care for injuries due to automobile accidents should be included in the "basic benefits" guaranteed by the health care system on the same basis as care for other injuries or illnesses. Auto insurers should continue to cover claims for the cost of more extensive auto-related medical care, such as long-term treatment for catastrophic injuries. Auto insurers should not, however, pay for treatments of the types covered by the basic benefits plan except to the extent and on the terms of that plan. Thus, any cost controls applied with respect to health care covered by the basic plan would apply to treatment of auto accident-related injuries just as they would to treatment of any other injuries or illnesses.

6. Prevention of Cost-Shifting. Providing for health care payments by auto insurers on the same terms as other health insurance payments is critical to prevent cost-shifting to the auto insurance system. A new health care system that fails to apply the same cost controls to auto-related medical expenses as apply to other medical expenses will exacerbate the adverse effects of cost-shifting.

7. Internalization of Costs. Automobile drivers should remain accountable for their costs. Auto insurance policies therefore should continue to finance the costs of auto accident-related health care. This will ensure that automobile insurance premiums continue to reflect the costs of automobile accidents.

WRITTEN TESTIMONY
OF THE
NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES
ON THE TREATMENT OF
AUTOMOBILE AND WORKERS COMPENSATION INSURANCE
AS PART OF HEALTH CARE REFORM LEGISLATION
BEFORE THE SUBCOMMITTEE ON
COMMERCE, CONSUMER PROTECTION, AND COMPETITIVENESS
FEBRUARY 1, 1994

Madame Chair,

Thank you for the opportunity to submit this testimony to the Subcommittee on Commerce, Consumer Protection, and Competitiveness.

The National Association of Mutual Insurance Companies (NAMIC) is the largest property and casualty insurance company trade association in the world with over 1250 member companies. Our membership is diverse, ranging in size from small county mutuals to large companies that have become household names.

The membership of NAMIC recognizes that all Americans should have the security of stable and affordable health insurance. Under our current structure, 85 percent of Americans have health insurance and access to high quality care. NAMIC believes that in providing care to those who lack coverage, we should enhance and build upon our current system that works so well for so many people. NAMIC supports reforms such as eliminating waste, fraud, and abuse in the health care system, adopting underwriting reforms, changing the tax treatment of some health insurance premiums, and promoting the formation of voluntary health purchasing cooperatives in order to make health care more affordable for small businesses and individuals who are currently uninsured.

NAMIC believes that free market forces should be allowed to continue to reduce the cost of health care. For example, NAMIC insures over 1000 employees of its member companies located throughout the United States. In the last five years, the association has been successful in decreasing the cost increases by over 50 percent through various cost containment measures and educating the insured on responsible usage of health services. Government mandated price controls could lead to a decrease in the quality of care for all Americans. The health care system should continue to be run by the private sector and monitored by the states. States should have the flexibility to adopt plans that most effectively provide access to health care to their citizens.

Because NAMIC is the largest property and casualty insurance company trade association in the world, we have a particular interest in the automobile and workers compensation provisions contained in Title X of the Health Security Act.

Automobile Medical Coverage

As stated in our guiding principles on health care reform, NAMIC believes there are elements of the current health care system that can be improved. Should health care reform be implemented through a massive restructuring, we believe property and casualty insurers should continue to provide for auto accident-related medical expenses through the medical portion of property and casualty insurance policies.

One of the goals of reform is to reduce the cost of health care through medical cost management techniques and managed care. It is critical that medical care provided to auto accident patients be subject to the same cost containment techniques as medical care covered by health insurance or health plans. A new health care system that fails to apply the same cost controls to auto related medical care as apply to medical care for other accidents and illnesses will almost certainly lead to cost shifting to the auto insurance system.

NAMIC believes that any comprehensive reform of the health care delivery system should provide for coordination of the medical portion of automobile insurance with the new health care system. By coordinating the delivery of medical care, auto accident patients would receive care only on the basis of the arrangement provided under their health plan. Thus, injured persons would not be entitled to a greater degree of care if injured in an auto accident than they would receive for a similar injury resulting from some other cause.

In order to effectively coordinate the auto and health insurance systems, it is important that health care reform specify that duplicate payment for health care expenses is prohibited. Auto insurers should only be required to pay the health care system for related medical expenses. Injured individuals should not be permitted to receive direct payment as a result of liability claims or other insurance for medical expenses that have already been paid by an insurer. If an injured individual is unable to recover medical expenses that have been paid by insurance, there will no longer be the incentive to over-utilize health care services in order to receive reimbursement proceeds which can be personally pocketed.

In addition to eliminating the ability to collect more than once for each medical bill, health care reform legislation should also address abuse with regard to fraudulent claims for health benefits. These provisions should apply to all forms of health care fraud, including those that are made in connection with an automobile accident.

NAMIC believes that the insurance industry's current system of financing auto-related medical costs is serving the public well and functions to establish accountability through the insurance pricing mechanism. Maintaining this system will ensure that automobile insurers continue to have an incentive to push for safe highways and safe vehicles. It also helps to keep health care insurance affordable for employers. Thus, we believe any effort to merge automobile medical insurance into a national health insurance system would be counter-productive and should be vigorously resisted.

Workers Compensation

The effect of health care reform on the workers compensation system has yet to be determined. Because of its uniqueness, NAMIC believes that workers compensation and health care reform should be considered as separate issues.

Today, many states have workers compensation systems that are viewed as models of efficiency. Others have undertaken substantive reforms such as the adoption of effective medical cost containment mechanisms. Today's workers compensation system contains incentives for employers to create and maintain safe work places. Complete and accurate data bases concerning the causes and costs of occupational injuries provide an efficient and understandable basis for those incentives. The system also promotes rehabilitation and return to work through high-quality, specialized occupational medical care and the guarantee of no-fault protection for injured workers. The doctrine of "exclusive remedy" remains a deterrent to costly litigation.

Should Congress address the issue of workers compensation as part of health care reform, the issue of cost shifting must be addressed. NAMIC believes that this objective can be met without dismantling the effective workers compensation systems in place. Ideally, NAMIC believes that health care reforms should be implemented and allowed to work before proposals to alter the workers compensation system are considered.

Thank you for allowing NAMIC to submit this testimony. We look forward to working with the Subcommittee and Congress to build upon the aspects of our health care system that provide the best care in the world to the majority of Americans in order to control costs and increase access.

**CHUBB & SON INC.**

15 Mountain View Road, P O Box 1615, Warren, New Jersey 07061-1615

January 31, 1994

The Honorable Cardiss Collins
Subcommittee Chairwoman
Commerce, Consumer Protection and
Competitiveness Subcommittee
United States House of Representatives
Energy & Commerce Committee
Washington, D.C. 20510

Re: Health Security Act - Title X

Dear Chairwoman Collins:

On behalf of Chubb & Son Inc., I would like to thank the members of this Committee for the opportunity to provide comments on Title X, Coordination of Medical Portion of Workers Compensation and Automobile Insurance, of the proposed Health Security Act. Chubb & Son has been in the insurance business since 1882, and is the manager of the member insurers of the Chubb Group of Insurance Companies writing property and casualty insurance through independent agents and brokers worldwide.

Although Title X pertains to workers compensation and automobile insurance, I will only be commenting on the workers compensation provisions.

Workers Compensation is a unique social insurance mechanism, designed as a "no-fault system" to provide an efficient method for resolving disputes related to workplace injuries and illnesses. In exchange for compensating employees for injuries arising out of the course of their employment, the employees are barred from suing their employers for negligence. Workers compensation insurance, which employers are required to purchase in nearly all states, provides for the costs of hospital and medical care treatment for injured employees, and for wage loss and survivorship benefits.

Because an employer's loss experience is a primary factor in determining its workers compensation insurance premium, all employers have an incentive to adopt safe workplace procedures. Workers compensation insurers provide loss control services that go well beyond those provided by the Occupational Safety and Health Administration (OSHA). In most cases the cost of these services are included in the insurance premium. Other optional loss control services may also be made available to the employers for additional

Cardiss Collins
January 31, 1994
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fees. Such services have included emphasis on VDT, carpal tunnel syndrome, ergonomics and stress-related injuries.

In addition, many of the individual state workers compensation reform bills passed in the past recent years have included requirements that workers compensation insurers customize safety programs for individual employers. It is unclear under the proposal what the impact any change in the delivery of health care benefits will have on workplace safety benefits employers receive under their workers compensation policies.

Another component in the current workers compensation system that needs to be maintained is the continued capturing of statistical data by the National Council on Compensation Insurance ("NCCI") and state regulatory authorities. Information captured by the NCCI includes identification of employers which are complying with the state workers compensation laws by purchasing coverage, detailed claim information, loss experience information by individual employer as well as by employee classification, and similar information provided by both insurance carriers and self-insurers. This already existing mechanism should be considered in light of the carrier premium filing requirements set forth in Section 10021 (b)(1) of the proposal.

These are but a few of the aspects of today's workers compensation system that work very well. With this as background, I would like to comment on a few components of the proposed plan.

Coordination of Benefits

As a provider of workers compensation insurance, we are cognizant that the primary reason for increasing costs to employers of workers compensation coverage is the increased costs of benefits paid to injured workers. In this regard, medical care delivery is one area that is most in need of reform. We strongly support a coordinated approach to workers compensation medical benefits. It is important that an injured employee receive medical treatment from a provider skilled in disability management who understands the purpose of workers compensation is to facilitate prompt return to meaningful employment. Workers compensation is not just a benefit delivery system but instead a disability management system.

By continuing to keep state-based workers compensation insurance systems separate from other health benefits delivery systems, carriers would manage both medical care and lost wage benefits paid to injured workers, thereby benefitting the injured

Cardiss Collins
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employees and the employers whose costs for such employees are capped by payment of the premiums. It is also not clear that an employee's lost wages would be covered under the proposal.

Case Management

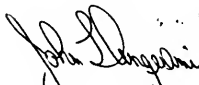
The proposal provides that the designated case manager be employed or contracted by the health plans; the case manager would then coordinate the plan of treatment with the workers compensation carrier, employer or both (Section 10001(c)). For effective case management we believe that the workers compensation insurer should be the case manager. If the case manager is designated by the health plan rather than the workers compensation carrier, there could be duplicate case management which would add additional cost to the system. Also, because the plans would be under enormous pressure to reduce administrative expenses, case managers would have no incentive to invest heavily in workers compensation case management and coordination. As a result, extended and unnecessary medical treatment could in turn extend lost wage benefits, all of which will be reflected in the premiums paid by employers.

Fee Schedules

Under the proposal health plans would be reimbursed by workers compensation insurers according to fee schedules to be developed by regional health alliances or pursuant to negotiated arrangements between insurers and health plans (Section 1001(a)(1)). While we believe a better approach would be to have non-alliance workers compensation health care providers and specialty provider networks, if there were to be a mandated merger and health care alliance procedure in place, a well reasoned certification procedure should be adopted.

I understand that over the course of the next several months there will be additional legislative drafting and further proposed revisions to the Health Security Act. I hope that you will take these comments into consideration as you make changes to Title X. I again want to thank this Committee for the opportunity to share these thoughts and observations on health care reform as it relates to workers compensation insurance. I would be happy to answer any questions you may have.

Sincerely,



John L. Angerami
Vice President

STATEMENT
OF THE
NATIONAL ASSOCIATION OF INDEPENDENT INSURERS
BEFORE THE
SUBCOMMITTEE ON COMMERCE, CONSUMER PROTECTION AND COMPETITIVENESS
OF THE COMMITTEE ON ENERGY AND COMMERCE
U.S. HOUSE OF REPRESENTATIVES
ON
H.R. 3600

The National Association of Independent Insurers (NAII), opposes health care reforms which call for the merger of the medical coverages of auto and workers compensation insurance into the health care system. This is but one of a number of reasons NAII opposes enactment of the Administration's Health Security Act (H.R. 3600).

NAII is a nonprofit voluntary property casualty insurance trade association of more than 570 property and casualty insurance companies. NAII members write more than 35% of the private passenger automobile insurance and 10% of the workers compensation insurance in the U.S. We welcome the opportunity to comment on the auto and workers compensation portion of the Health Security Act.

The Clinton Administration's health care reform proposal (introduced in Congress in October 1993 as the Health Security Act of 1993) initially calls for the "integration" or coordination of the auto and workers compensation insurance medical coverages under the new "managed competition" style national health care system. At first, auto and workplace injuries would simply be treated under the revamped health care system but financed by auto and workers compensation insurers. In a few years, the health care system would handle both the financing and treatment of these injuries. The "integrated" system has its origins in "24 Hour Coverage," a concept which would merge auto and workers compensation medical insurance with health insurance, whether through a governmental program or private carriers.

Through the years, NAII has long supported the position that auto insurance should be the primary source of benefits to compensate or reimburse injury sustained through the use of a motor vehicle.

In 1993, the NAII Board of Governors revisited the primacy issue in the context of the current health care reform debate. We concluded there were no new circumstances to justify altering the Association's view on the primacy of auto medical coverage.

NAII's position opposing the merger of auto and workers compensation medical coverages into the health insurance system is based on three distinct rationales:

- Under auto and workers compensation medical coverages, motorists and employers pay, rather than government and ultimately taxpayers, for the cost of auto crash and workplace injuries.
- Auto and workers compensation insurance are experience rated, which means that the costs of workplace and auto crash injuries are allocated more heavily to employers that maintain unsafe workplaces and motorists that drive irresponsibly through higher insurance premiums. Such a system is fair and promotes greater highway and workplace safety.
- Disconnecting the medical coverage from auto and workers compensation insurance will severely handicap the cost management and settlement of the remaining indemnity claim covered by the auto or workers compensation policy.

This could result in higher than necessary claim payments for wage loss, disability, pain and suffering and other compensable damages, thus negating whatever cost-savings advantage proponents envision through the merger of auto-workers compensation medical coverage into a national health insurance system.

The current system of experience rating of property-casualty Insurance coverages allows insurers to weigh risk factors and price accordingly. Premium discounts for drivers with good records and surcharges for risky drivers are a fair way of apportioning costs and persuading motorists to drive more cautiously, purchase safer cars or improve their driving skills. If auto insurers' financial interest in keeping down the costs of medical coverage and injury claims is removed, they would be less inclined to dedicate considerable financial resources to injury prevention and auto safety.

Perversely, under the Clinton plan U.S. taxpayers would be forced to subsidize the medical costs of reckless drivers and employees subjected to unsafe working conditions. (Health care accounts for 47 percent of workers compensation losses, and 20 percent of personal automobile losses, according to Insurance Service Office (ISO) statistics.

Because of that business incentive, auto insurers have played a major role in advancing highway safety programs in the U.S. for decades, pushing for safer automobiles, taking auto manufacturers and the federal government to court over their refusal to implement airbag technology, and lobbying for seatbelt, motorcycle helmet and drunk driving laws for the last 15 years. They have spent millions of dollars in establishing and helping support the Insurance Institute for Highway Safety (IIHS), a research and crash testing organization that is one of the leading forces in highway safety research.

The interest of auto and workers compensation insurers in promoting injury and loss prevention, safety awareness, and public education on the cost of injury has had other societal payoffs. The National Safety Council was founded and remains funded by safety-minded organizations, a number of which happen to be leading auto and workers compensation insurers. Auto and especially workers compensation insurers are responsible for many significant medical advancements in the rehabilitation of serious injuries incurred at the workplace.

The workers compensation system has inspired the creation of occupation injury medical centers and clinics, many of which are located close to large industrial sites, providing convenient and specialized health care and therapy for workplace injury victims. Workers compensation insurers, and to a more limited degree, auto insurers increasingly are using managed care techniques to stabilize rising medical expenses associated with workplace and auto crash injuries.

Proponents of "24 Hour Coverage" or of the merger of all medical coverages into the public health system are frankly guilty of myopic vision. It is not known whether a "one doctor treats all injuries" comprehensive health care system can achieve greater administrative efficiency, simplicity or cost savings over the current system. In addition, proponents of such a system have failed to account for the negative effect their unified health insurance plan may have on the settlement of residual auto and workers compensation insurance claims. For instance, the nature and extent of a workplace injury is crucial for the workers compensation insurers and has a direct bearing on:

- the length and ultimate severity of the disability;
- the awarding of compensation for the disability portion of the workers compensation claim; and
- the application of special occupational injury treatment and rehabilitation.

Today, workers compensation insurers manage the treatment of the injury with the goal of returning the worker to the workplace as quickly as possible. Under the Administration's proposal it appears that management of the claim is placed in a "case manager" who is an employee of the general health plan.

In view of the health care plan's objective of holding down costs, will the case manager have the incentive to expend the funds necessary to ensure that the worker is quickly returned to work? If the injured worker is treated under the general care system, will the workers compensation insurer have the needed access to specialized information and the ability to oversee the treatment? Without an oversight role in the management of workplace injury treatment, workers compensation insurers are precluded from guiding the medical care or rehabilitation to assure that the principal objective of the workers compensation system (to see the injured party return to work as expeditiously as possible) is being achieved. Will related workers compensation disability and wage loss payments increase? These are potentially adverse "side effects" of ill-conceived health care reform that merit serious consideration.

There is yet another reason why lawmakers should proceed cautiously before transferring to the federal government the responsibility for treating and financing health care costs related to workplace and auto crash injuries. Merging the medical coverage under auto and workers compensation insurance into governmental or private health insurance programs has serious fiscal ramifications. With budgets at the breaking point, can the taxpayers afford to assume an even greater financing role in health care costs? Are public policymakers willing to take political responsibility for forcing health insurance policyholders or employees to pay for health care costs associated with vehicle crashes and workplace injuries?

According to statistics derived from the A.M. Best Company, the Insurance Research Council, and NAI, auto insurers made an estimated \$11.1 billion in incurred loss payments under private passenger (insurance claim payments and reserves) auto insurance policies in 1992 relating to medical care coverage. That same year, auto insurers paid out another \$1.6 billion in medical expense-related claims under commercial auto insurance policies. The loss payments would be attributable to claims filed under bodily injury liability coverage, uninsured/underinsured motorist claim, personal injury protection (no-fault law states) coverage, and medical payments coverage. This is a countrywide statistic, but the auto insurance medical loss payments can be equally staggering depending on the state. The attached charts depict "estimated auto insurance losses attributable to medical care" breaking down the health care losses currently paid under personal and commercial auto insurance by state. Merging auto medical coverage into the state's health insurance system will transfer significant new health care cost exposures to government and private health insurance programs. According to the Insurance Services Office (ISO), health care-related costs accounted for \$12.2 billion of privately insured workers compensation losses in 1992. Can the proposed health care system afford to absorb these costs?

Although much of the country seems caught up in the rush to improve and "reform" the health care system, NAI is urging public policymakers to remember the logical and compelling reasons for retaining auto and workers compensation medical coverage as the primary health care benefit for injuries sustained while operating a motor vehicle or while at the workplace.

In addition, these are monumental decisions the Congress will be making as the Health Security Act is considered. Hasty action by the Congress will not serve this country well. The consequences of ill conceived and hasty action can cause harm not only to our nation's health care system but to the economy as a whole.

HEALTH CARE REFORM

MONDAY, FEBRUARY 14, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON COMMERCE, CONSUMER PROTECTION,
AND COMPETITIVENESS,
Chicago, Ill.

The subcommittee met, pursuant to notice, at 10:02 a.m., at Circle Center, University of Illinois, Chicago, Ill., Hon. Cardiss Collins (chairwoman) presiding.

Mrs. COLLINS. Good morning. This hearing of the Energy and Commerce Subcommittee on Commerce, Consumer Protection and Competitiveness will come to order.

Let me say that I am delighted to have this hearing at the University of Illinois. We usually have our hearings over at the Federal building and the room that we usually have those hearings in was taken and, as they have always done when we have asked the university to accommodate us for the various functions of the seventh congressional district, they have done so most willingly. I certainly want to thank Mr. Steuker and all the university personnel for being such friends of ours as we continue to do the work of the seventh congressional district.

Let me say, too, we have invited all of the members of the subcommittee to be here today. Many of them had various places they had to be, having hearings in their own districts, and could not be here. However, our record will remain open for their opening statements and other comments that they would want to make a part of the full record.

I am delighted, too, before we get into the actual hearing process, to see a very dear friend of mine, Patty Spivey, who used to put a lot of these hearings together herself when she worked for the United States House of Representatives. I am sure there are going to be some moments here when you can remember the things that we used to do together years and years ago. Welcome. I am glad to have you here.

This hearing is the 13th in a series of hearings held by our subcommittee on health care reform issues. President Clinton's proposal, known as the Health Security Act, would establish a health care delivery system in which every American is enrolled in a health plan of their choice among health plans whose service areas include the area in which that individual resides.

State governments would have the responsibility of regulating health plans through each State's insurance department or otherwise, and ensuring compliance with requirements and standards

for health plans. Among the bill requirements and standards are a few that are especially pertinent to today's hearings. Health plans would be prohibited from discriminating in any way on the basis of race, national origin, sex, language, socioeconomic status, age, disability, health status or anticipated need for health services.

A health plan's service area could not be tailored to avoid certain groups of people and their marketing material could not be distributed only to some groups and neighborhoods within their service area while excluding others.

One of the requirements upon which State certification of a health plan is dependent is the health plan's capacity to deliver health services throughout its service area. State regulators will also have the responsibility to ensure that each enrollee will have an adequate selection of health plans from which to choose, and a State may require as a condition of certification that one or more health plans include certain locations within their service area.

A State may also offer specified incentives to ensure that members of disadvantaged groups are adequately covered.

To ensure that health plans would be adequately compensated for enrolling a greater percentage than average of higher risk people, those who cost more to cover, the Health Security Act calls for the development of a risk adjustment mechanism.

Through risk adjustment, the payments for each health plan would be slightly increased or decreased according to the level of risk of their enrollees. This would also help ensure that there would be no incentive to try to circumvent the prohibitions against the selection of healthier people at the exclusion of others.

In recent years, providers of health care services in the Chicago metropolitan area have begun to collaborate to form full service provider networks. These networks provide numerous advantages: One, they are designed to provide health services more cost-effectively over the long run due to the principle of economies of scale and the efficient utilization of resources with minimal duplication; two, more people have greater access to one-stop shopping for the full array of medical services; three, hospitals and practitioners have the opportunity to benefit from the advances in medical technology and techniques at other facilities which can result in enhanced quality of care for patients.

In the greater Chicago area, a number of very large networks have developed in recent years. Among them are the Rush Prudential Health Plans, the Northwestern Healthcare Network, and the EHS Health Care system, each of whom we will be hearing from today.

Some of the Chicago area networks will likely remain strictly as provider networks providing medical services while others will likely aim to participate as a health plan, bearing the insurance risk as well as providing all the medical services. Even those provider networks that do not intend to underwrite the risk are still very likely to participate in a reformed system as full service, large scale networks that contract with those who will bear the risk and jointly functioning as health plans.

These networks, too, are positioning themselves for the possibility of a long-term change in the health care delivery system.

The evolution toward health plans in the Chicago metropolitan area, while presenting many advantages, raises a number of concerns, too. Among these concerns that are to be addressed today are:

One, do some of the provider networks currently target only certain neighborhoods while avoiding others, as reflected by the locations of facilities that are invited into the networks?

Two, in the case of networks whose providers are now predominantly located in wealthier, nonminority and/or suburban neighborhoods, to what extent will those networks try to expand in the short term into poor, minority, and underserved urban neighborhoods?

Three, are provisions in the President's bill for a risk adjustment methodology sufficient to deter plans from targeting the most affluent and healthiest populations?

Four, will public hospitals have an equal opportunity to compete and will they be adequately compensated for their patient base which is higher risk and more reliant on government aid?

Five, how well equipped is the Illinois State government to accept the regulatory responsibilities conferred upon it by the President's bill, and if not well equipped, would it prefer that health plans be regulated by the Federal Government?

Six, is the Illinois State government's past record in policing insurance redlining a significant indicator of its ability to protect against discriminatory practices by health plans?

And finally, what safeguards do consumers who reside in traditionally underserved neighborhoods need to assure them of fair, nondiscriminatory treatment and choice of a full range of health plans that provide access to services equal to that available to other Chicago area residents?

The subcommittee looks forward to today's hearing and the testimony from this very distinguished group of witnesses. Welcome. I welcome our witnesses.

Our first panel will consist of Dr. Bruce Spivey, the president of Northwestern Health Care Network; Dr. Leo Henikoff, the president of Rush Presbyterian-St. Lukes Medical Center; Mr. Richard Risk, the president and CEO of EHS Health Care; and Mr. Richard Ferguson, director of planning, Cook County Bureau of Health Services, who is pinch hitting for Ms. Patricia Terrell, deputy chief.

We welcome you.

The House of Representatives operates under a 5-minute rule which basically says that each of you, each person testifying, will be provided with 5 minutes to basically summarize your statement. At the end of that 5-minute period of time, then we will begin to ask questions, and probably much of what you want to say, if you hadn't had an opportunity to say it during your 5 minutes, will come out during that time.

I want to assure you that your full written statements will be made a part of the record. We are ready to begin with you, Dr. Spivey.

STATEMENTS OF BRUCE SPIVEY, PRESIDENT, NORTHWESTERN HEALTHCARE NETWORK; LEO M. HENIKOFF, PRESIDENT, RUSH-PRESBYTERIAN-ST. LUKES MEDICAL CENTER; RICHARD R. RISK, PRESIDENT, EHS HEALTH CARE; AND RICHARD FERGUSON, DIRECTOR OF PLANNING, COOK COUNTY BUREAU OF HEALTH SERVICES

Mr. SPIVEY. Good morning, Congresswoman Collins. I am Bruce Spivey of the Northwestern Health Care Network. I am pleased to be here today to testify before your subcommittee concerning the Health Security Act with respect to the provider networks in the Chicago metropolitan area and their implications for consumers.

The Northwestern Health Care Network today is comprised of four institutions: Northwestern Memorial; Children's Memorial; Evanston with two hospitals, Evanston and Glenbrook; and Highland Park. Each of these has as its mission a provision of superb health care to the people in their community.

The vision of integrated delivery system led these hospitals to create the network which along with additional members in the future will provide cost effective care and ensure continued high-quality care.

As you are aware, the marketplace is causing dramatic changes in the health care delivery system. Chicago is not leading these changes. California, Minnesota, Massachusetts, for example, are leaders. We are, however, beginning to change to be able to respond to managed care on a regional basis.

This requires close cooperation between physicians and hospitals, both locally and across the region. This will require the Northwestern Health Care Network and similar networks or systems to have institutions and physicians throughout Chicago. These regional networks are sometimes integrated health care delivery systems and if health care reform nationally occurs as envisioned by the President in H.R. 3600, they will function as health plans providing care to individuals over a wide range or region under the aegis of an alliance.

Thus, we are responding to both the marketplace and Federal reform as we work to complete a truly regional network. Inherent both in the marketplace and in H.R. 3600 is competition, cost-effectiveness, and quality, each system will want and need to be able to provide service for all members of the community.

It is natural for your committee to want to understand how network evolution and growth will impact on access to care for the historically poor, underserved, and minority communities.

The goal of the Northwestern Health Care Network is to offer superb health care to all people in the metropolitan Chicago area. Our member hospitals have a proud tradition of caring for poor people in underserved communities. We have not and will not participate in any kind of redlining to exclude any community or individual from obtaining access to our network.

Our current member hospitals serve a sizable Medicaid population as well as underserved communities. Children's Memorial Hospital is the fifth and Northwestern Memorial the fourteenth largest provider of Medicaid patient base in Illinois out of the 209 hospitals Statewide.

The network serves Medicaid patients throughout the Chicagoland area. Children's Memorial has for more than a century provided state-of-the-art pediatric care to every child in need without regard to the child's financial means. More than 50 percent of the inpatient care rendered at Children's Memorial is for patients who depend on Medicaid.

Northwestern Memorial has consistently provided substantial levels of uncompensated care and the number of Medicaid patients is rising steadily including a significant increase in 1993. Northwestern Memorial provides residents of the Cabrini Green public housing complex comprehensive prenatal care through the hospital's Prentice Ambulatory Care Program. More than $\frac{1}{3}$ of the births are to indigent mothers.

Our network maintains a strong relationship with Winfield-Moody Health Center with locations in the Cabrini Green and West Town area. Our member hospitals have had a long association and commitment to these communities. The center evolves from community health centers initiated by Children's Memorial and Northwestern Memorial in the 1960s.

Northwestern Health Care Network intends to continue to encourage this type of outreach. Currently we are talking with various hospitals and physician groups in other communities throughout metropolitan Chicago to include the south and west side of Chicago. We are committed to a broad base of community involvement in our network.

In summary, President Clinton's health care plan has as an overriding objective: Universal coverage for all Americans. We share the President's health care goals. We commend you, Madam Chairwoman, for your leadership in conducting this hearing and in seeking to provide access to quality care for all citizens throughout America.

You can be assured that the Northwestern Health Care Network is committed to providing quality health care, lowering costs, eliminating duplication, and serving the entire Chicago metropolitan area.

I would be happy to answer questions.

Thank you.

Mrs. COLLINS. Thank you. We didn't have to raise our little sign on you to give you the time. You did less than the time.

[The prepared statement of Dr. Spivey follows:]



NORTHWESTERN
HEALTHCARE
NETWORK

Testimony presented by Dr. Bruce Spivey, President, Northwestern Healthcare Network before the House Subcommittee on Commerce, Consumer Protection and Competitiveness on February 14, 1994

Children's Memorial
Medical Center

Good morning, Congresswoman Collins and other distinguished members. I am Bruce Spivey, M.D.. I am the President of the Northwestern Healthcare Network in Chicago. I am here today to testify before your Subcommittee concerning H.R. 3600, the Health Security Act, with respect to the provider networks in the Chicago metropolitan area and their implications for consumers.

Evanston Hospital
Corporation

The Northwestern Healthcare Network is comprised of four hospitals each of which has as its mission the provision of superb care to the people of its communities. The vision of an integrated delivery system led these hospitals to create the Network which would provide cost-effective care and insure continued high quality of care into the future.

Highland Park
Hospital

Before I begin to further describe the Northwestern Healthcare Network, it is important to understand the various factors both locally and nationally that have contributed to hospitals and physicians uniting to create health care systems. Let me take a few minutes to explain what these dynamics are.

Northwestern
Memorial Corporation

One major factor for hospitals and physicians to align themselves into regional health care systems has been the evolution of reimbursement from fee-for-service to managed care, which means discounted and pre-paid systems. Its becoming the predominant vehicle for hospital and physician payment. Under this form of payment, the incentive is to treat patients in the most appropriate and least expensive setting. Thus, regional systems are developing because they are more cost effective and reduce the risk to any one hospital or physician.

Furthermore, many hospitals and physicians are seeking to join a network because of the Clinton health care plan which calls for the establishment of Regional Alliances to which all Americans will belong. These Alliances will ultimately seek a relationship with the health care networks in the regions which have the lowest cost and highest quality system. However, many states are not waiting for the Clinton health care plan to be adopted and are enacting major health care reforms in their own states. Many of these initiatives propose contracting with health care systems in a capitated basis. Hospitals and physicians in Chicago must move ahead to quickly align themselves to respond to these market conditions by forming networks that are cost effective and that can provide quality health care.

In addition, reductions in Medicare and Medicaid reimbursement rates are forcing hospitals and physicians to align themselves to lower costs and increase efficiencies. Banding together on a regional basis will minimize the duplication of costly services and equipment which will further reduce costs.

Lastly, the growing surplus of hospital beds has further exacerbated inefficiencies. The results of technological advances have caused a shift from inpatient to an outpatient treatment. In the last ten years in Chicago, total patient days have dropped 32% and inpatient admissions have declined 15%. In my opinion, this decline in inpatient utilization will lead to a bed surplus of nearly 50% in the six-county Chicago area by 1999.

The shift from inpatient treatment to alternative care settings has brought physicians, hospitals and payors into direct competition with each other. Realizing the resultant inefficiencies and duplication of services, providers have thus begun to develop formalized relationships with each other on a regional basis.

The effect of these combined factors have led to integrated systems of care. As a result hospital and physician networks are growing and becoming more visible. Most free-standing hospitals are talking to existing provider networks about developing affiliation. As the existing Chicago area health systems seek to expand across the city and suburbs, they will be competing to become the leaders in integrated care. The system leaders of tomorrow will be those who are prepared to act now in a deliberate and proactive manner. The Northwestern Healthcare Network is one such network that has responded to these market forces and is in a state of transformation and growth.

With this important background information, let me briefly describe for your Subcommittee how the Northwestern Healthcare Network evolved to its present structure and our plans for further expansion before I begin to discuss our commitment to serving the disadvantaged and underserved communities.

The Northwestern Healthcare Network was originally formed in order to respond to health care purchaser demands and community needs. There is presently a profound shift in the structure of health care delivery toward managed care. This emphasis on managed care and cost containment are compelling reasons for NHN to rapidly develop into an integrated health care system. It is the intent of the Network to help ensure that its Hospitals and physician members are prepared to operate effectively and successfully in a managed care environment.

The Northwestern Healthcare Network was created in 1989 and reached its functional stage in November 1993. The Network is a multi-institutional health care system serving Chicago and the surrounding region. The network consists of The Children's Memorial Medical Center, The Evanston Hospital Corporation (including Evanston and Glenbrook Hospitals), Lakeland Health Services, Inc. (including Highland Park Hospital), Northwestern Memorial Corporation (including Northwestern Memorial Hospital). Northwestern University Medical School also participates through a master affiliation agreement with NHN. Currently, the hospitals in our Network are located on the north and northwestern parts of metropolitan Chicago. Northwestern Healthcare Network is the holding company over these four entities and serves as the sole corporate member of each.

The movement toward integrated care in the Chicago area has resulted in several emergent health care systems. Presently, none of the existing systems provide regional access over the entire metropolitan area. Each of Chicago's health care systems is looking for growth in a variety of ways: managed care contracting; responding to the needs and interests of employers directly purchasing health care services; expanding and capitalizing on high volume services like obstetrics, pediatrics and cardiology; and strengthening their relationships with academic and research programs.

The results of competition will be to lower costs and provide quality care. Each system will want to be viewed as the leading proponent of a quality solution to the health care needs of the entire Chicago community.

Our Network is faced with significant challenges as we expand and develop into an integrated system of health care. As the health care world braces itself for the forthcoming changes in its fundamental delivery system, the Northwestern Healthcare Network will focus its energies on objectives in three critical areas: physician development, network system development and managed care development.

First, in the area of physician development, we want to expand the Network's primary care physician base in order to respond to the geographic and service needs of purchasers and consumers. The Network will work with its current physicians and member institutions to expand the existing base of primary care physicians who are able to deliver high-quality, cost-effective care. To expand geographic coverage, the Network and its Hospitals will also be adding primary care physicians, either individually or in groups.

Second, Network system development and expansion will be based on the balance of services, settings and primary care physician/specialist mix required for geographic coverage.

Third, a key to managed care development will be the regular interaction among the Network staff, employers and payors so that the Network can better understand and develop responses to meet purchaser needs. The Network will establish a payor/employer council to provide a vehicle for communicating Network responses to specific payor needs as the managed care market matures.

The health care systems that will emerge as leaders are the ones that respond to several important market demands. Some of these demands are to:

1. provide successful care.
2. provide excellent value at a predictable and affordable cost.
3. attract a wide range of patients through extensive geographic coverage to include underserved communities.
4. develop the strongest ability to compete in the managed care market through access and quality.
5. incur trust, confidence and a reputation for sensitivity, availability and good care among all patients and payors.
6. improve the health care status of Chicago.

Now, I would like to address this Committee's concerns about the expansion of the Northwestern Healthcare Network and how it will impact on access to care for underserved communities. Our goal is to offer superb health care to all people in the metropolitan Chicago area. All of our members hospitals have a proud tradition of caring for poor people and underserved communities. We have not and will not participate in any kind of redlining to exclude any community or individual from obtaining access to our Network.

Our current member hospitals service a sizable Medicaid population as well as underserved communities. The Children's Memorial Hospital is the 5th and Northwestern Memorial the 14th largest provider of Medicaid patient days in Illinois out of 209 hospitals state-wide. Overall, our Network services Medicaid patients throughout the Chicagoland area to include the far south-side and west-side of Chicago.

Children's Memorial has, for more than a century, provided state of the art pediatric care to every child in need, without regard to the child's financial means. More than 50 percent of the inpatient care rendered at Children's Memorial is for patients who depend on Medicaid. In fiscal year 1992, Children's delivered nearly 34,000 days of care to children on Medicaid. In addition, Children's absorbs the costs of caring for hundreds of uninsured children and underinsured children. In fiscal 1992, Children's delivered \$10 million in bad debt and charity care.

Like many inner-city hospitals that serve a disproportionate share of medicaid patients, Children's Memorial is a safety net--a hospital of last resort for children who have no place else to go.

Northwestern Memorial Hospital (NMH) has consistently provided substantial levels of uncompensated care, with the number of Medicaid patients rising steadily, including a significant increase in 1993. NMH provides residents of the Cabrini Green public housing complex comprehensive prenatal care through the hospital's Prentice Ambulatory Care Program. Nearly one-third of the births at NMH's Prentice Women's Hospital are to indigent mothers. In fact, just recently NMH committed to more than doubling the number of high risk pregnant women cared for in a new clinic dedicated solely to treating indigent high risk pregnant women. Extensive perinatal care is also provided to indigent families. In addition, NMH provides health services to Medicaid patients by participating in the Chicago Trauma Network. In 1993, NMH provided more than \$40 million in uncompensated and unreimbursed care, covering thousands of clinical visits and hospitalizations for patients in need.

The Evanston and Glenbrook Hospitals have a long and proud tradition of providing health care services to all who come to them for help, regardless of ability to pay. Through our Outpatient Clinic, Child and Adolescent Center, Dental Clinic, Outpatient Psychiatry Clinic, and Ocular Center, they provide care to community residents whose income fall within federally established Medicaid income guidelines. They offer subsidized care and charge on a sliding-fee scale based on the patient's ability to pay. In 1993 alone, they provided the equivalent of \$24 million in community service and uncompensated care, covering more than 40,000 clinic visits and hospitalizations for patients in need and bad debt. In addition, their outpatient pharmacy provides prescriptions at cost to clinic patients.

Our Network maintains an on-going relationship with the Winfield-Moody Health Center with locations in Chicago's low-income Cabrini-Green public housing community and in the West Town area. Our member hospitals have had a long term association and commitment to these communities. The Center was incorporated as a not-for-profit corporation in 1982.

The Center's roots reach back more than twenty years with the merger of two separate community health care centers: one serving children founded in 1966 by Children's Memorial Hospital and another serving adults which was founded in 1969 by Northwestern Memorial Hospital. In November 1987, the Center completed a capital campaign which built the Winfield/Moody Health Center (WMHC), a new facility designed to accommodate 48,000 occasions of service yearly.

The mission of the Center is to provide high quality primary care health services that are financially, geographically and sociologically accessible to a minority, low-income population. Services are available on a sliding fee scale basis for those not covered by Medicare, Medicaid or private insurance. No patient is denied treatment due to an inability to pay.

The ethnic composition is about 59% African-American in the Cabrini -Green area and 35% Hispanic in the nearby West Town community. The Center offers innovative and easily accessible primary health care services to the people of these communities. In 1991, the Center saw more than 11,000 patients in over 37,000 outpatient visits. Almost 16,000 visits are made by underprivileged women to Northwestern's Prentice Women's Hospital and Maternity Center. The Network regularly admits patients from this facility and avails the Winfield-Moody Center of its clinical and administrative expertise. With Network support, the Center has received national recognition for its innovative preventive medicine programs and other health initiatives to address the special needs of an inner city population. Northwestern Healthcare Network expects to continue and encourage this type of outreach. Currently, we are talking with various hospitals and physician groups in other communities throughout metropolitan Chicago to include the far south and west-side of Chicago. We are committed to a broad base of community representation in our Network.

In summary, President Clinton's health care plan has as an overriding objective universal coverage for all Americans. We share the President's health care goals. We commend you, Congresswoman Collins, for your leadership in conducting this hearing and in seeking to provide access to quality health care for all citizens throughout America. You can be assured that the Northwestern Healthcare Network is committed to providing quality health care, lowering costs, eliminating duplication and continuing to serve the entire metropolitan Chicago area.

Thank you very much. I would be pleased to answer any questions.

Mrs. COLLINS. Dr. Henikoff.

STATEMENT OF LEO HENIKOFF

Mr. HENIKOFF. Thank you Congresswoman Collins, and may I start by saying how great it is to have the chairwoman of the Subcommittee on Commerce coming from our own district here in Chicago.

Mrs. COLLINS. Thank you.

Mr. HENIKOFF. I would like to tell you a little bit about the Rush System and then to make a couple of comments on the Clinton act, if I may.

The Rush System goes back quite a ways because it was designed as a vertically integrated health care delivery system with the intent to cover metropolitan Chicago, and this concept was developed in the late 1960's and implemented in 1971 so we have been building what has turned out to be described as an accountable health plan for the last 23 years.

As part of that, we began Anchor HMO in 1971 as our first entry into the insurance part of the health care delivery system and that entry has expanded today into a 50 percent ownership of Rush Prudential Health Plans that enroll over 400,000 people today in the Chicago area.

What is interesting, I think, about the Rush System is that it was designed to meet the needs of people, the whole system, including the academic part of the system, so that in the late 1960s, the concept was what do you need to serve 1.5 million that are a broad population, a diverse population, what do you need in terms of care delivery and what do you need in terms of health professionals? The system was designed as a population-based response.

I do want to point out that for the past 24 years in the design and development of that system, the concept of fair share of indigent care in that system and any others that were developed in Chicago was a basic tenet of the system.

Today there are 8 hospitals that are participants in the Rush Health System, and 2 days ago a 9th declared their intent to join the system. That represents over 3,000 licensed hospital beds and over 2,000 operating beds, and it involves also a huge commitment to primary care throughout the Chicago metropolitan area.

I won't bother to list the members of the Rush System. They are listed in the document that I have provided. I do want to mention a new relationship of the Rush System with Cook County hospital. Today, we have in place an integrated surgical residency. The Rush Primary Care Institute, which is described to some extent in my written testimony, is going to have a joint presence with Cook County in their ambulatory care activities. And probably most important is a joint venture with the Cook County Bureau of Health Services in the development of the Cook County/Rush Health Center which is to be an ambulatory facility placed here on the west side of Chicago with an investment, a capital investment in the area of \$30 million to serve patients with communicable diseases, primarily AIDS and related communicable diseases, so that the commitment of this system to the west side of Chicago and to the entire metropolitan area, and the commitment of this system to indigent care as a fair share commitment of its responsibility to the

area has been there for 24 years and is demonstrated in the programs that we are developing.

If I might, I just want to mention some comments on the Health Security Act more broadly. They are mentioned in my written testimony. The health alliances do create a very large bureaucracy and I think it is important to weigh whether this bureaucracy has a payoff in terms of better care for people through the health alliances or can the health alliances have less regulatory function and serve as a vehicle for community rating for health insurance which seems to be very desirable to us.

We have grave concerns about funding health care reform out of further cuts in Medicare as Medicare recipients may end up with a second tier level of care if cuts continue too long. An important point that I want to make that I think is not generally recognized is that under the Health Security Act, cost shifting from the public sector to the private sector continues unabated because Medicaid recipients will not be reimbursed to the health plans at the same rate as other enrollees, and I think that deserves some very special care and study because the opportunity for Medicaid abuse under that system is great.

On education of health professionals, the Clinton plan should be applauded in that it does address the special needs of institutions that both conduct research and educate health professionals of all kinds for the future. I think that the response in the Clinton plan to that need should be studied carefully to see whether or not these two functions will be able to continue under the level of funding provided.

And my final statement had to do with some description of the Rush Institute for Primary Care which is one of our strategies to respond to the needs of this region and the country and does, I think, coincide, I think, very well with the intents in the Health Security Act.

Thank you, very much for the opportunity to give this testimony.
Mrs. COLLINS. Thank you.

[The prepared statement of Dr. Henikoff follows:]

Statement by Leo M. Henikoff, M.D., President and Chief Executive Officer of Rush-Presbyterian-St. Luke's Medical Center to the Subcommittee on Commerce, Consumer Protection and Competitiveness on H.B. 3600, the Health Security Act, on Monday, February 14, 1994, in Chicago.

I am delighted to appear at this hearing to present the views of the leadership of Rush-Presbyterian-St. Luke's Medical Center concerning the contribution we hope to make towards health care reform through the Rush System for Health.

As an institution, Rush has been preaching the "systems" or "network" gospel since 1971, a time when it was fashionable to refer to the American health care system as a "non-system." Whatever truth there may have been in the appraisal, it was clear to us that change was called for, that elements of this "non-system" were constantly warring among themselves to the detriment of quality, cost containment and access to health care.

Our proposed solution was the establishment of a geographically organized, self-contained, vertically integrated system that included primary, secondary and tertiary care capabilities, a managed care component, fee-for-service options, and an academic health center to train manpower for the system. We had the "patent," as it were, but rather than guard it jealously, we urged the formation of similar, competing system in the region to help deal with the problems that had proliferated under the old "non-system."

Few institutions responded to that invitation, but time and experience have validated its main points. Today, over 20 years later, we can see how trends in health care have evolved toward a more organized, managed system of providing care. Much of this impetus came, it is true, from employers who had seen their health premiums mount steadily and decided to apply pressure through united action to obtain favorable rates from different providers.

Notwithstanding, it became widely accepted that some sort of health reform was needed and the various health reform proposals now before Congress recognize these trends toward managed care while leaving open the option for a fee-for-service choice.

The Rush System for Health is organized with the capability not only to be comprehensive provider of care but also an insurer with multiple health plan options. It can, in fact, function under any of the proposed health reform plans or, in the absence of any governmental restructuring of the system, within the present trends in health care financing and delivery.

At the core of the Rush System is Rush-Presbyterian-St. Luke's Medical Center, which includes Illinois' largest private hospital --Presbyterian-St. Luke's -- the Johnston R. Bowman Health Center for the Elderly, the Rush Home Care Network, and Rush University. The Medical Center is linked, either through corporate affiliation or joint venture, with the following institutions: Rush North Shore Medical Center, Skokie (North suburbs), Holy Family Hospital, DesPlaines (Northwest suburbs), Illinois Masonic Medical Center (North Side, Chicago), Oak Park Hospital, Oak Park and Westlake Community Hospital, Melrose Park (West suburbs), and Copley Memorial Hospital, Aurora (Far West suburbs). The Medical Center is also looking for similarly close relationships with hospitals in other parts of the metropolitan area, including the south and southwest suburbs. When complete, the Rush System will include about 10 participating hospitals serving about 13 percent of the patients in the metropolitan region. It also includes five occupational health centers in the city and northwest suburbs.

In a major reconfiguration within the Rush System, the Medical Center merged its managed care programs last year with those of the Prudential Insurance Company of America. The joint venture, which is owned equally by both partners, is called Rush Prudential Health Plans and serve more than 1,200 employers and 365,000 members. The merger was guided by considerations of equality, accessibility and affordability.

In sum, the Rush System presents a core group of participating organizations, each retaining autonomy but assuring their futures through reciprocating relationships. The strategic placement of member hospitals assures that almost all of the metropolitan area will eventually be under the Rush System umbrella, that is, Rush-related facilities and professional personnel will be easily accessible in all parts of the region. Under this definition, the medically underserved, wherever they may be located, will in a similar fashion have access to the Rush System. We expect that each member institution of the Rush System will be willing to do its fair share of ministering to the health needs of the underserved, each in appropriate response to the special requirements of its community.

In the context of the foregoing, we wish to cite several examples of institutional initiatives arising from community needs. Rush-Presbyterian-St. Luke's, by virtue of its location, has a large volume of inner city patients.

We maintain an active outreach program of health screenings, inoculations and health promotion through our Community Affairs department. Although Cook County Hospital, our next door neighbor, is not a member of the Rush System we are cooperating with it in a number of areas, including an integrated surgical residency. Last month, our two institutions announced plans for the Cook County/Rush Health Center, a new facility to combine and expand the capabilities of both institutions in

an innovative, comprehensive approach to the research, prevention and treatment of HIV, tuberculosis and sexually transmitted diseases.

Another member of the Rush System, Illinois Masonic Medical Center (IMMC) enjoys an informal reputation as "the preferred Hispanic hospital on Chicago's Northside." As Chicago's population grew from 14% to 20% Hispanic, Illinois Masonic recognized the need to provide bilingual services and programs specifically focused on the needs of the Spanish speaking people of Chicago. Although located in Lakeview, a neighborhood which is only 13% Hispanic, IMMC has undertaken outreach efforts to bring quality medical care to its neighboring underserved communities.

For example, over 35% of IMMC's nearly 20,000 inpatient discharges in 1993 identified themselves as Hispanic and 54% of the 3,350 babies born at IMMC in 1993 are of Hispanic heritage.

Turning to the provisions of the Health Security Act as now proposed, we have the following comments:

On Health Alliances:

The Health Security Act creates regional health alliances to be established and governed by the states to qualify health plans, assess the quality of health plans, enforce health budgets, enroll employers and employees in the new system, collect premiums and in effect become the single purchaser of health care for all except the employees of some large firms who elect to establish a corporate-sponsored alliance. This, in effect, excludes any direct contact by the employer with the health plans providing coverage to its employees.

Except for making available purchasing cooperatives for small businesses and individuals these health alliances would seem to be an unnecessary bureaucracy

between the purchaser and the insurer when most of the problems that have been identified can be resolved by health insurance reform.

We agree with the recommendation of the American Hospital Association which is:

The size of health alliances should be limited to serve only small businesses and individuals. They should have a limited administrative role, rather than a regulatory role. Their scope should be limited to four basis functions:

- o Serve as a risk pool for small businesses and individuals
- o Offer an open enrollment period with the opportunity to join any of the qualified health plans
- o Disseminate easily comparable data on quality, cost and enrollee satisfaction to the public about each plan
- o Collect community-rated individual and small business premiums and distribute risk-adjusted premium amounts to the health plans

On Reduction in Medicare Reimbursement

The largest source of financing for the health plan is a shifting of \$124 billion of funds from the existing Medicare program. ProPac has estimated that Medicare was already paying hospitals an average of 9.9% less than cost in fiscal year 1992 and cuts of \$56 billion were made as a part of OBRA 1993 for deficit reduction. This current underfunding is being recovered by hospitals from cost shifting to other payers. The Medicare reductions in reimbursement proposed to finance health reform would only make this existing problem worse.

The Medicare program is being maintained separate and apart from the system proposed for all other individuals. The continued and increasingly underfunded

payment system for the individuals in the Medicare program is likely to create an access problem similar to that now experienced by those in the Medicaid program.

On Medicaid Cost Shifting:

Although one of the goals of universal coverage has been the elimination of cost shifting through the establishment of an equitable payment by all third party payers for their sponsored enrollees, this is not accomplished by the Health Security Act. The per capita payment for Medicaid recipients of 95% of the currently existing cost as provided in the Act, contains the current Medicaid cost shifting that is now in effect in the various states. The Illinois Medicaid payment to hospitals is significantly below cost which results in costs being shifted to other payers. This cost shifting would continue under the proposed plan as a part of the premiums being charged to employers and individuals.

On Education of Health Professionals:

For a provider network that includes an academic health center to be cost competitive with other networks, the cost of graduate medical education and education of nurses and other health professionals needs to be financed proportionately over the entire health care system. The Act provides a mechanism for such financing but careful attention needs to be directed to the adequacy of the funds being allocated for this purpose.

On Primary Care Physicians:

The Act makes provisions for increasing the number of physicians trained in primary care and a decline in those trained in specialty fields. Rush Medical College is committed to encouraging its medical students to pursue a career in one of the primary care fields. To attract medical students to the primary care areas we have established the Rush Institute for Primary Care.

This Institute promotes five initiatives to achieve the goal of supporting a successful primary care delivery network. These initiatives are the following:

- o **Primary Care Practice Support:** Services designed to identify the needs of primary care providers and improve the provider practice patterns.
- o **Primary Care Education:** Efforts include the modification of medical student and resident curriculum to increase exposure to primary care and the development of a curriculum to retrain subspecialists.
- o **Primary Care Research:** Efforts include the development of a practice-based research network and a research center for outcomes, health services, and practice protocols.
- o **Information Services:** The creation of an information system network to connect hospitals and physicians throughout the System
- o **Community Outreach:** Efforts to expand access to populations with limited primary care access.

Mrs. COLLINS. Mr. Risk.

STATEMENT OF RICHARD RISK

Mr. RISK. Thank you, Congresswoman Collins, for inviting me here today. I am pleased to be able to share with you some information about my organization, EHS Health Care.

EHS is one of the largest providers of health care and wellness services in metropolitan Chicago. Our 11,300 employees and 1,850 physicians are dedicated to providing quality, cost-effective health care that meets the needs of individuals, families, and society.

Last year the system's hospitals served more than 570,000 people. Home health visits rose to almost 125,000. Our nursing home days increased to almost 130,000. And nearly 120,000 people a year availed themselves of a variety of health education and wellness programs sponsored by EHS.

In addition, EHS provides about \$60 million a year in charity care as well as unreimbursed services to Medicare and Medicaid patients.

Founded in 1906 and related to the United Church of Christ, EHS owns three suburban and two city hospitals and has just completed an affiliation with Ravenswood Hospital Medical Center on Chicago's north side. The system's five own hospitals are EHS Christ Hospital in Oak Lawn, EHS Good Samaritan Hospital in Downers Grove, EHS Good Shepherd Hospital in Barrington, and EHS Bethany and Trinity Hospitals in Chicago.

We recently established a 5-year affiliation agreement with the University of Illinois that ties us to the university's academic and research programs in the health sciences and establishes the UIC College of Medicine as the primary sponsor of EHS Christ Hospital's integrated graduate medical education programs.

In addition, we operate the largest full service home health care company in Chicago. We own 4 nursing homes totaling 588 beds and have a 50 percent ownership in Health Direct, a large managed care company that incorporates both a PPO and an HMO.

The community served by our more than 75 care sites are diverse. They range from the inner city where median household income totaled just \$20,000 and median home values stand at \$58,000 to middle class neighborhoods where income is \$59,000 and home costs \$100,000 to more affluent suburbs where incomes are at \$60,000 and home values top \$170,000.

As EHS contemplates the future of health care in the metropolitan area, we have made several key assumptions. One, we believe that comprehensive health care reform will be passed by the Federal Government within the next 2 years.

Two, we expect buyers of health care who will buy care on a region-wide basis want better quality and value for their money. Three, we believe patient care will continue to shift from an inpatient setting to a variety of outpatient settings as well as the patient's home, and the focus of care will shift from treatment to prevention.

Four, we expect the health care market to consolidate further. And 5, we believe that by the year 2000 most people, including Medicare and Medicaid enrollees, will be covered by managed care

plans and providers will be paid on a capitated basis to take care of the enrollees.

The network we are building is designed to succeed in this new environment. It is designed to offer community residents throughout the Chicago area various points of access to a network that will provide accessible quality care at a reasonable price.

There will be a depth of coordinated services available, kind of a one-stop shopping concept that will minimize the complexity of health care delivery for the consumer and maximize customer satisfaction.

Our strategic vision states EHS Health Care in partnership with physicians will become the health care delivery system of choice. Committed to improving the health and wellness of people residing in the greater Chicago region, EHS will lead the formation of strategic alliances in order to offer a community-based continuum of care access through aligned health plans.

With our partners, we will be accountable for health outcomes, customer service and efficiency, while successfully operating under fixed population-based payments. EHS will continue its commitment to meeting community needs.

To reach this strategic vision, we have identified six core strategies. Three are of particular relevance to the testimony sought today. Physician integration, network development, and payer partnership.

Together these three strategies seek to develop relationships with physicians, other provider groups, and payers of health care that will enable EHS to deliver cost-effective, high quality health care services through a continuum of delivery settings in the 6-county Chicago region.

Thank you for your attention. I will be happy to answer any questions you may have.

Mrs. COLLINS. Thank you, very much.

[Testimony resumes on p. 250.]

[The prepared statement of Mr. Risk follows:]

RICHARD R. RISK
President and Chief Executive Officer
EHS Health Care

THE EHS HEALTH CARE NETWORK - Providing Accessible Health Care

Thank you, Congresswoman Collins and the rest of the members of the Sub-Committee, for inviting me here to testify today about network development in the Chicago area. I am pleased to be able to share with you some information about my organization, EHS Health Care.

Overview of EHS Health Care

EHS Health Care, headquartered in Oak Brook, Illinois, is one of the largest providers of health care and wellness services in metropolitan Chicago. It is dedicated to providing quality, cost-effective health care that meets the needs of individuals, families and society. Helping provide that care are 11,300 employees, 1,850 physicians, and 2,900 auxiliaries and volunteers. The number of people that we employ makes us one of the 20 largest employers in the Chicago area.

Range of Services

In 1993, the system's five owned hospitals served 570,692 people, an 8 percent increase from the 1992 total. Although admissions declined 3 percent to 66,366, outpatient registrations rose 10 percent to 364,270, and emergency room visits increased 8 percent to 168,595. Almost 12,500 babies were born at EHS hospitals during the year. In the non-acute care divisions, home health care visits rose 28 percent to 123,936 while resident days at EHS Health Care nursing homes rose 4 percent. In addition to patients served within EHS facilities, the system reaches out to people within its communities through a variety of health

education presentations, wellness programs, support groups, health fairs and open houses. Nearly 120,000 people participate in such programs annually. In addition, it is estimated that the system provides about \$60 million a year in charity care as well as unreimbursed services to Medicare and Medicaid patients. The system also has established a Church as a Place of Healing program that supports the healing ministries of United Church of Christ (UCC) congregations. Programs include grants for community services as well as family life education events and health care career scholarships.

Types of Facilities

Founded in 1906 and related to the United Church of Christ, EHS Health Care owns five hospitals with 1,821 beds and has an affiliation agreement with a sixth hospital, operates the largest full-service home health care operation in the Chicago region, and manages extended care centers, day surgery and outpatient diagnostic facilities, physicians office buildings and retirement complexes. In addition, EHS operates a mental health counseling network. The system recently concluded a five-year master affiliation agreement with the University of Illinois that connects EHS with the university's academic and research programs in the health sciences. A subordinate affiliation also was established between the University of Illinois at Chicago (UIC) College of Medicine and EHS Christ Hospital and Medical Center that establishes UIC as the primary medical college affiliate of EHS Christ Hospital. Finally, the system has a 50 percent ownership in Health Direct, a large managed care company that operates both a Preferred Provider Organization (PPO) and a Health Maintenance

Organization. In total, EHS has more than 75 owned or affiliated care sites throughout the metropolitan area.

Details about major operations follow:

- EHS Christ Hospital and Medical Center, Oak Lawn, is an 814-bed teaching and tertiary care center that was opened in 1961 and provides trauma care for the South Side of Chicago and the south suburbs;

- EHS Good Samaritan Hospital, Downers Grove, is a 386-bed hospital that has become one of the leading providers of care in the western suburbs since its opening in 1976;

- EHS Good Shepherd Hospital, Barrington, is a 154-bed community hospital especially known for its obstetrical services ever since its opening in 1979;

- EHS Bethany Hospital, Chicago, is a 204-bed facility newly opened in 1984 that is a major health care and community resource for the West Side;

- EHS Trinity Hospital (formerly known as South Chicago Community Hospital), Chicago, is a 263-bed hospital that was founded in 1895 and merged into EHS Health Care in 1988;

- Ravenswood Hospital Medical Center, Chicago, is a 462-bed community teaching hospital on the North Side that affiliated with EHS Health Care on February 3, 1994;

- The EHS Home Health Care Division operates EHS Home Health Care Service, Concerned Care, EHS Hospice and HealthSource, which together provide home health services, technology and equipment;

- The EHS Extended Care Division operates four nursing homes with 588 beds: EHS Geneva Care Center in Geneva, EHS Peace Memorial Home in Evergreen Park, EHS

Pine Acres Care Center in DeKalb and EHS Pine View Care Center in St. Charles;

- Outpatient centers include the High Tech Medical Park in Palos Heights, the EHS Good Samaritan Naperville and Oakbrook Terrace Campuses, the Midwest Center for Day Surgery in Downers Grove and the Naperville Surgical Centre;

- Ten Family Care Network counseling offices are located in Aurora, Barrington, Chicago, Downers Grove, Lockport, Oak Lawn, Palos Park, Tinley Park, Villa Park and Western Springs, plus three Child Sexual Abuse Treatment and Training Centers are in Bolingbrook, Chicago and St. Charles;

- Nine retirement residences, providing 715 apartments for low-income senior citizens and handicapped adults, are in Barrington, Chicago (4), Downers Grove (2), Evergreen Park and Glenview;

- Health Direct, a joint venture with Lutheran General HealthSystem offers a PPO covering more than 250,000 lives and an HMO, which began operations in October 1993, that covers 3,500 lives. In addition, EHS Health Care covers about 400,000 lives through direct contracts with major buyers of health care.

Demographics of Communities Served

Although EHS Health Care's non-acute care divisions are experiencing steady growth, the largest numbers of people served by EHS are those who come to the system's hospitals for services. The communities served by these hospitals are diverse, much like the metropolitan area itself. In most cases, these communities also are served by other, smaller EHS Health Care facilities. In the primary service area of each hospital, these are the demographics:

■ EHS Chnst Hospital and Medical Center, Oak Lawn

- 612,117 population in 1992
- 51.8 percent female, 48.2 percent male
- 15 percent age 65 and over
- Median age 34.8
- Median years of school completed 12.7
- Median household income \$39,329
- Median home value \$99,804
- 84.3 percent white (non-Hispanic)
- 3.5 percent black
- 10.7 percent Hispanic

■ EHS Good Samaritan Hospital, Downers Grove

- 631,065 population in 1992
- 50.9 percent female, 49.1 percent male
- 9.3 percent age 65 and older
- Median age 33.6
- Median years of school completed 15
- Median household income \$56,551
- Median home value \$163,605
- 88.9 percent white (non-Hispanic)
- 2.9 percent black
- 3 percent Hispanic

■ EHS Good Shepherd Hospital, Barrington

- 267,616 population in 1992
- 50.3 percent female, 49.7 percent male
- 8.1 percent age 65 and older
- Median age 33.6
- Median years of school completed 14.4
- Median household income \$59,663
- Median home value \$170,765
- 94.5 percent white (non-Hispanic)
- 0.5 percent black
- 2.9 percent Hispanic

■ EHS Bethany Hospital, Chicago

- 335,131 population in 1992
- 51.1 percent female, 48.9 percent male
- 6.5 percent age 65 and older
- Median age 26.1
- Median years of school completed 11.5
- Median household income \$20,287
- Median home value \$57,724
- 3.6 percent white (non-Hispanic)
- 65.3 percent black
- 30.5 percent Hispanic

■ EHS Trinity Hospital, Chicago

- 406,423 population in 1992
- 54.2 percent female, 45.8 percent male
- 11.1 percent age 65 and older
- Median age 33.1
- Median years of school completed 12.7
- Median household income \$28,614
- Median home value \$65,722
- 5.9 percent white (non-Hispanic)
- 85.1 percent black
- 8.7 percent Hispanic

EHS Health Care's Strategic Direction

In November 1993, EHS Health Care's board of directors approved a new strategic plan based on several key assumptions:

- Comprehensive health care reform will be enacted by the federal government within two years. This, coupled with continued growth in managed health care, is expected to shape the future of health care delivery.
- Buyers of health care will expect better quality and value for their money.

Health care providers will compete for patients on price, convenience and customer service.

- Patient care will continue its shift from an inpatient setting to a variety of outpatient locations. The focus of care will shift from treatment to prevention.
- The health care market will consolidate further. Regional health systems will grow, the number of physician group practices will increase, physicians and systems will integrate, and the managed care market will consolidate. In the end, the dominant health delivery systems and managed care plans will form strategic partnerships.

In short, we believe that by the year 2000 most people will be covered by managed care plans (including those citizens covered by Medicare and Medicaid) on a capitated rate basis. These assumptions are key to understanding why we are in the process of expanding our health care network. This network is and will be designed to serve all of the Chicago area by providing community residents with various points of access to enter our network. These points of access could be outpatient centers, hospitals or primary care physician groups located within a reasonable commuting distance from residents' homes.

For a health care consumer, a network such as ours will assure him/her of accessible, quality care at a reasonable price. In addition, there will be an in-depth range of coordinated services available--a "one-stop shopping" concept that will minimize the complexity of health care delivery and maximize customer satisfaction.

Our Vision 2000, which is our overall strategic objective, provides a succinct description of where EHS would like to be in the year 2000:

EHS Health Care, in partnership with physicians, will become the health care delivery system of choice, committed to improving the health and wellness of people residing in the greater Chicago region. EHS will lead the formation of strategic alliances in order to offer a community-based continuum of care accessed through aligned health plans. With our partners, we will be accountable for health outcomes, customer service and efficiency, while successfully operating under fixed population-based payments. EHS will continue its commitment to meeting community needs.

To reach this strategic vision, EHS Health Care's new strategic plan identifies six core strategies for the next three years:

- 1) Physician Integration
- 2) Network Development
- 3) Payor Partnerships
- 4) Operations Excellence
- 5) Organization Change
- 6) Christian Mission

Of most relevance to the testimony sought by the Sub-Committee today are the first three strategies.

Physician Integration is defined as a strategic imperative for EHS. To be able to survive in the consolidated health market predicted for the future, EHS and its affiliated physicians realize they must emerge as a single economic unit. Together, we must be capable of single-signature contracting with employers, government and other payors. We must share

financial risks and rewards. And we must be committed to jointly delivering cost-effective, high quality health care services across a full continuum of delivery settings. To help accomplish these goals, EHS is in the process of setting up Physician Hospital Organizations at all its hospital locations.

Network Development refers to the expansion of EHS Health Care's delivery capabilities by mergers and affiliations with other provider organizations. This will allow us to provide comprehensive coverage to the full six-county Chicago region and to further develop the range of our health care services. The recent affiliation agreement with Ravenswood Hospital Medical Center is an example of this network strategy. By 1996, EHS plans to become at least a 10-hospital health care delivery system. In addition, the system will build a fully integrated physician network made up of approximately 570 primary care physicians and 760 specialists. Affiliated physician practices will be geographically dispersed throughout the six-county area. There will be continued expansion of EHS Health Care's continuum of care services through wellness and health promotion, ambulatory care services, older adult services, home health care and new service delivery settings. EHS also hopes to establish community health networks that will implement contractual relationships with non-affiliated providers so as to reduce duplication of expensive equipment and facilities and thereby reduce the internal cost structure of participating organizations.

Payer Partnership calls for EHS Health Care to implement tactics to redefine its relationships with intermediary organizations. These tactics will include (1) performing in-house functions such as network formation, care management and financial risk assumption historically executed by third party managed care organizations and (2) pursuing strategic

alliances with dominant managed care plans. In seeking a strategic alliance with a leading HMO, EHS Health Care would act as the preferred provider network for the HMO. The system also plans to support the growth of Health Direct as an owned, managed care plan subsidiary.

As EHS succeeds in accomplishing its strategic goals in these three areas--Physician Integration, Network Development and Payor Partnership--we believe we will enhance our opportunities for accomplishing our foundational strategy--Christian Mission. This strategy, which goes back to our roots as a church-founded organization, calls upon us to enhance the health and wellness of our communities. To do so, we remain committed to

- Expanding access to health care services for underserved populations;
- Delivering health care services at all affiliated facilities according to an approach that ministers to the needs of the whole person--body, mind and spirit;
- Implementing health promotion and wellness programs that provide broad community benefit through positively impacting public health status; and
- Addressing underlying social problems in communities served that impact indirectly on community health status.

Thank you for your attention. I hope this testimony has been helpful in broadening your understanding of EHS Health Care and its network development activities in metropolitan Chicago.

Mrs. COLLINS. Mr. Ferguson.

STATEMENT OF RICHARD FERGUSON

Mr. FERGUSON. Yes. I am Richard Ferguson, the director of planning for the Cook County Bureau of Health Services, pinch hitting, as you say, for Patricia Terrell, who apologizes for not being here this morning.

Cook County Bureau of Health Services is, one, the largest health care delivery system in Illinois and one of the largest public health and hospital systems in the country.

I want to emphasize in the testimony today the significant role that the public sector has played and continues to play in serving underserved populations. Let me highlight that by giving you a few statistics about Cook County Hospital.

We provide—more than 2,500 people come into the hospital every day. We provide 3 times more emergency room visits than the next busiest hospital in Chicago. We operate the largest Level I trauma center in the Midwest, providing for 40 percent of all trauma care in Chicago, more than half of which is the result of violence.

The hospital's clinics provide over 500,000 visits every year and our outpatient pharmacy fills 5,000 prescriptions daily, the equivalent of 26 Walgreens. One in every nine patients in our hospital has AIDS or HIV and the number is rising at a rate of 20 percent annually. More than 50 rooms within the hospital to accommodate the isolation needs of a growing new public health scourge, which, of course, is actually an old public health scourge, tuberculosis, which has come back surging.

Approximately 35 percent of our outpatient visits and 55 percent of our inpatient visits are covered by Medicaid or Medicare, and the vast majority of the rest are without any insurance or other ability to pay for their care.

In addition to Cook County Hospital, the bureau operates a community teaching hospital on the south side of Chicago, the longest long-term care hospital in the State, the Suburban Cook County Department of Public Health. We also provide the health services for the incarcerated population at Cook County Jail, which has approximately 80,000 inmates per year, every single one of them has to be screened for STD, TB, and other diseases. And we have a growing network of community-based health centers.

Because of cuts in Medicaid eligibility, a growing number of people who are without medical insurance, and the emergence of new and complex public health problems, reliance on county health care services continues unabated.

Why do I tell you all of this? I tell you because you need to understand that public health and hospital systems like Cook County have for decades served as the safety net provider for those with no other option, those for whom the various national health proposals are being designed to help. We have unique experience in caring for those who have been cut out of the health care system.

We worry about the proposed gaps in coverage which would exclude undocumented residents and prisoners because such an omission is not only poor public health, it is shortsighted fiscal policy. We worry about potentially inadequate incentives necessary to cre-

ate new community-based primary care capacity in inner-city neighborhoods and in rural areas.

We worry about the lack of specificity on the support of a strengthened public health infrastructure because so many of the medical problems that we see at Cook County Hospital and in other county health facilities day in and day out are directly related to poverty, to homelessness, to drug addiction, to poor education.

We worry about a competitive model because few providers will likely compete for the communities which we now serve or the high cost services—like trauma, burn, and neonatal care—which we now provide. And we worry about a transition period during the phase-in of health reform during which many health care providers—doctors and hospitals who have been in the trenches delivering care to underserved populations and communities—may not be adequately supported.

These issues concern us and we are working diligently to assure that they are addressed sufficiently.

Despite our concerns, we support the move for comprehensive health reform. One critical and encouraging element of the Health Security Act is the proposed support for the development of community networks. Over the past 2 years, the bureau has been moving expeditiously to create regional networks of our own facilities and partnerships with other public and private providers.

We have defined the communities in which Cook County patients live and have targeted the development of comprehensive primary health care centers for those neighborhoods.

Finally, we have established consumer-dominated district health councils in the regions in which these networks are being created to assure that the services appropriately address the real health needs of the communities.

We decided to become proactive in the development of public sector networks for several reasons. First, we do not believe that there will be a groundswell of providers seeking to put resources in historically underserved communities.

Second, the health care problems faced by the people living in these communities require a broad base of expertise and experience that is unique to the public sector and other providers with long histories of working with underserved populations.

Finally, we are developing networks because we cannot afford not to. We must find new ways of caring for people in their own communities, preventing unnecessary hospital visits, cooperating with other providers to avoid duplication, and ultimately developing new strategies for keeping people healthy and out of the medical system.

As you debate the elements of health reform and particularly as you discuss the establishment of provider networks, please be aware of the special attention that must be given to underserved communities and underserved populations, both urban and rural.

Universal coverage will not guarantee universal access. As you know, even the Clinton proposal does not have universal coverage actually in it because it leaves out undocumented workers and prisoners. We also worry in relation to that the phase-in period may be extended into a much longer period of time than was initially laid out.

As you are all aware, there is a great deal of debate going on as we speak as to what extent there will be universal coverage and we worry about underfunding of the traditionally public sector providers, either Medicaid or the current uninsured.

Networks must assure geographically accessible and culturally acceptable care. Public health and prevention services must be incorporated into medical protocols in order to effectively treat illness. Start-up capital funding and other incentives must be provided to assure that health care infrastructure is built in communities which providers have traditionally shunned.

Universal coverage must be just that: universal. We must put mechanisms in place to minimize those populations which fall through the cracks.

Thank you.

Mrs. COLLINS. Thank you very much for your testimony.

In your statement, Mr. Ferguson, you mentioned, and I am quoting now from page 4 of the statement, "First, we do not believe that there will be a groundswell of providers seeking to put resources in historically underserved communities."

Why do you think that is the case?

Mr. FERGUSON. I think for several reasons. First of all, there is obviously a lack of financial incentives since many of the people in those areas have either inadequate coverage or no coverage and, as I mentioned, we are concerned that even under health reform there is likely to be compromises made toward the reimbursement of care for that population.

And as Dr. Henikoff pointed out as well, there are provisions in there which may lead to underfunding of the Medicaid population. So there won't be a large rush to serve this population. They also have complex social and health care problems which I think as public sector providers, we are very much aware of and have a lot of expertise in caring for those, but many other providers who have not traditionally provided care to that population lack that expertise and are likely—we fear will not adequately provide for the social support systems and deal with the more complex medical problems that these people face.

Mrs. COLLINS. Well, Dr. Spivey, 13 percent of the people that you service through your network are Medicare recipients.

What would be your response to that? Do you believe that there is not a groundswell of providers seeking to put resources in historically underserved communities?

Mr. SPIVEY. I think that historically Cook County in this area has provided that locus of care. And each of the institutions and systems has, in their own way, to provide a reasonable amount of coverage.

Now, I think that as the Health Security Act goes forward, it is very possible that with reasonable funding which is not—has not been available for many of the underserved that it will be in fact something very desirable for these networks to serve communities in proportions larger than they have historically.

Mrs. COLLINS. Dr. Henikoff, you service a large number of people who are disadvantaged.

Do you think there is going to be a resistance of various networks to include low-income people in their overall network or alliance or whatever we want to call it?

Mr. HENIKOFF. Do you mean under the proposed Health Security Act?

Mrs. COLLINS. Yes.

Mr. HENIKOFF. Actually not and I will tell you why. I think there certainly is a reluctance to date for many providers to go into underserved areas because reimbursement is so poor. I think that is true.

Some of us have our homes in underserved areas such as Rush and Illinois Masonic and Copley in our system and do a lot of both indigent and Medicaid services.

In the Health Security Act as proposed, the health plans will be reimbursed for Medicaid recipients at a rate equal to, on an annual basis for a given recipient, 95 percent of what that State's actual capitation was paid in the base year for Medicaid.

That is an interesting way to design the plan because I have data that are a couple of years old where Illinois was reimbursing hospitals at 56 percent of cost and New Jersey was, I believe, at 104 percent of cost at the top of the scale and that State-to-State difference would be maintained under the Clinton plan and set in stone.

So let's see what that means, then, to somebody getting care or paying for care in a particular State. Today the cost shift occurs at the level of the hospital. If hospitals in Illinois are paid 60 percent or 65 percent of costs for Medicaid, what they are charging other payers is at 150 percent of cost to make up the difference, and we know that cost shift is different from State to State.

Under the Clinton plan, in the health plans which I will call accountable health plans through the health alliance, those plans would be paid one rate for everyone they enroll except Medicaid and at the rate that I mentioned, the 95 percent of the base year payment by the State for Medicaid. And let's assume there is a significant difference in those two numbers.

Now, wisely, in the Clinton plan, they did not put that burden on the individual accountable plan that enrolled the people. They spread it across all the plans. So that if 10 percent of the enrollees through the health alliance are Medicaid, then 10 percent of all of the premiums paid to each health plan whether or not they enroll any Medicaid people are paid at the Medicaid rate.

So they have taken out that disincentive to have Medicaid in your particular health plan. That is why I said this may not be true.

But there is a corollary. What is known in the health insurance managed care business is that Medicaid recipients, although their health status is poorer, the cost of serving those people may be less, because there is less demand for expensive referrals coming from that population. A little-known fact.

And it is likely or possible that under the Clinton plan, the Health Security Act, if one targeted a Medicaid population—and then remember you are getting paid not at the Medicaid rate for serving that population, you are getting paid at your premium rate. That is the flip side, that you may be able to make a lot of money.

And I have written both of our Senators and the chairman of the House Ways and Means Committee on this issue saying that there is an opportunity for what I consider to be a rip-off of the Medicaid system under the Health Security Act for that very reason.

So we could see plans targeting Medicaid recipients because of financial positive outcomes and not delivering the kind of care that we would like to see delivered. It is an interesting flip side that could occur out of that act.

Mrs. COLLINS. Well, that is interesting. Let me go on. You haven't had an opportunity yet, Dr. Spivey, to hear Mr. Greenspan's (of Mount Sinai) statement yet.

Let me share what he says: "This combination of factors—an existing primary care network, comprehensive services, market penetration, high occupancy, and low cost—should make us an attractive partner hoping to serve our community."

Now, are these factors the criteria that makes for an attractive network partner, do you think?

Mr. SPIVEY. Yes. I think that a number of factors are important and are developing and certainly one is geography, and our particular geography has started to the north. Obviously we need complete coverage throughout the Chicago area.

The efficiency, the primary care capacity, the willingness to work in managed care, the quality of the institution as evidenced by its medical staff, the willingness of the medical staff to work with the institution, all are very important criteria to consider in adding institutions to the network.

Obviously, there are not enough—there are too many institutions for all of them to add into the existing networks. But certainly Mr. Greenspan's comments are right on target.

Mrs. COLLINS. Dr. Spivey, I wrote down some of the participants in your network. I wrote down Children's Memorial, Evanston Hospital, Glenbrook Hospital, Highland Park Hospital, and Northwestern Medical Center.

So let me ask you that: Is your network contracted with any of the hospitals or other major facilities on either the west side or south side of Chicago?

Mr. SPIVEY. We have had intensive discussions with a number of institutions both west and south. And as my colleagues here will indicate, it takes a long time to develop the relationship.

Technically we are 1 day short of 90 days of existence in the Northwestern Health Care Network. While it has been functioning in a superficial way over the last 3 years, it was not until November 15, 1993 that all of the institutions made the necessary commitments.

So we are 90 days old, so that has obviously allowed us not to proceed with the final negotiations in a number of institutions.

Mrs. COLLINS. Both Dr. Henikoff and Mr. Risk indicated in their written statements again that their networks are planning to include about 10 hospitals each in their networks once they are fully expanded.

Would it be possible for you to say approximately how many hospitals you want to have in your network at this time?

Mr. SPIVEY. That is a pretty good estimate, 10. We have 5 now. I am pleased to hear that Leo's is almost full with 9. In fact, I am delighted to hear that.

Mr. HENIKOFF. We have revised our estimate.

Mr. SPIVEY. I think, as you may well be aware, Madam Chairwoman, hospitals are not the epicenter of the universe in the health care paradigm of the future as they have been in the past, so the emphasis on hospitals that have existed—that has existed historically is not going to be at the same level in the future. Much more ambulatory care. Much shorter lengths of stay.

And in fact some estimate, and I do, that we may have 50 percent too many hospital beds in Chicago by the year 2000 if they stay at the present level, and this is based on the reality—this is based on the reality of what is presently occurring in California today. This is not an extrapolation or a guesstimate on an estimate, but it is days per 1,000 of care in both commercial and Medicaid.

If you look at that and put the entire Chicago population in present-day statistics with Californian tightly managed HMO's or IPA's, you will find that instead of the nearly 27,000 hospital beds, we probably need only 10.

The reality is we will never meet that 100 percent, so somewhere around half of our present operating beds by the year 2000, which I think is not something that the—it would appear that the Clinton plan, the Health Security Act, really has thought through or the implications thereof are not clearly understood by the government.

The reality is that many, many people are going not to be employed in the future in hospital activity and there are plenty of statistics and plenty of examples now beginning to develop that I think you and your subcommittee and the full committee may be interested to understand further.

Mrs. COLLINS. Dr. Henikoff, to what degree will your network, once it is expanded to its full extent, aim to serve the same percentage of patients from underserved and from other communities?

Mr. HENIKOFF. Our goal was to have our network, number one, serve the entire Chicago metropolitan area and to have our patient enrollment in the network in terms of diversity look like the diversity that is found in the Chicago metropolitan area. That is how we designed it and that is how we built it.

Mrs. COLLINS. Same question, Mr. Risk.

Mr. RISK. I would give a similar answer, Congresswoman. We are attempting to build a system to serve the entire Chicago area and if we are successful in accomplishing that, I would expect that the portion of the Chicago population that looks to EHS Health Care for all of its care would reflect the same diversity and socioeconomic mix that Chicago's population reflects.

Mrs. COLLINS. You know, Dr. Spivey, let me tell you, I do have a problem. I will tell you what the problem is. When I read the newspaper about the expansion of the network of Northwestern, it appeared to me that Northwestern was reaching for the more affluent communities within the Chicago metropolitan area and that did cause me some concern.

Now, the 13 percent of the Medicaid and indigent patients that you handle, where are they located basically besides Cabrini Green?

Mr. SPIVEY. The west, south. If you look at the statistics in the demographics of Children's Hospital, particularly, you will see they are from all over Chicago and that comprises over 50 percent of Children's admissions.

Clearly we started out with the institutions that have historically worked together and now we begin to go into areas, not north, as I mentioned earlier, but west and south.

Mrs. COLLINS. The question of primary care practitioners always comes before our committees as we have been having these hearings. I am going to ask Mr. Risk: To what degree will your network aim to achieve the same ratio of primary care practitioner to patient in traditionally underserved communities as in other communities?

Mr. RISK. Within EHS right now, we have approximately 2,000 physicians and about half of those would be identified as primary care physicians. Those are fairly well allocated across all of our hospitals.

And as you know, Congresswoman, Bethany Hospital serves the west side and Trinity Hospital serves the south side of Chicago and Christ Hospital serves as the trauma center for much of the south side.

In our training programs at Christ Hospital, we have about 140 residents. Most of those residents are in the primary care areas. Also with our new affiliation with the University of Illinois College of Medicine, one of the things which attracted us to them is that they are one of the—have one of the largest networks of residencies in primary care, so we can establish the opportunity to recruit those physicians as they complete their training to serve at our hospitals.

At Bethany Hospital in particular, for instance, Johnny Brown, the CEO there, is in the process of trying to put in place in the next 12 months about 10 to 15 primary care practices allocated around the west side of Chicago to further improve the outreach of Bethany Hospital and its programs into that community. So we are actively attempting to do that.

As you can imagine, those primary care physicians are going to be hotly contested for and the question will be whether or not we can provide an attractive practice opportunity for them when they complete their residency, but certainly it is our intent to be present.

Mrs. COLLINS. I am more familiar with Rush Presbyterian Hospital, but for the record I would like for you to answer the same question, please, Dr. Henikoff.

Mr. HENIKOFF. We have traditionally put an emphasis on primary care at Rush. To my knowledge in the Chicago area, there are only two medical schools that have family practice departments and Rush is one.

I think we are the only medical school in the country where a family practitioner is dean of the medical school. That has a lot of influence, as you know, on academic programs.

We have put together a Rush Primary Care Institute that has several goals. One goal is to upgrade the status of primary care in the academic environment. You know, I cringe every time I hear a faculty member anywhere in the country talking about a student and saying to the student, "Well, you are smart enough to be a cardiologist. Why do you want to go into internal medicine or family practice or pediatrics?" And it does happen.

The culture needs changes and we are trying to change both the academic culture and then to create for primary care physicians a home that includes strong communications with each other and with continuing education. This includes research, the kind of research that I believe the country feels has to be done in health care delivery, health services research which are based in the primary care institute.

So it is a major initiative both to educate more physicians who go into primary care, to upgrade the status of the profession of primary care delivery, and to create a home that will make it more attractive for primary care practitioners not to be so isolated and to burn out in primary care practice.

Mrs. COLLINS. Same question, Dr. Spivey.

Mr. SPIVEY. As you are well aware, Congresswoman, historically primary care has just, as has been described, not been an emphasis in most medical centers, particularly most tertiary medical centers.

We have roughly $\frac{1}{3}$ primary care and $\frac{2}{3}$ specialty care. We are much like the patterns around the country, if you were to count up most of the tertiary centers here in Chicago. Our challenge is to get that far, more a 50-50.

As you also are well aware, there is a major thrust nationally to reduce the number of specialty or subspecialty programs and augment that with primary care programs. Certainly that is our intent. This is going to be, as Mr. Risk indicated, a very intensive phase of trying to make a link with primary care physicians throughout Chicago and we are certainly going to be a part of that.

Mrs. COLLINS. I am interested in the degree to which your network might aim to achieve the same ratio of primary care practitioners to patients in the traditionally underserved communities as in other communities, Dr. Spivey.

Mr. SPIVEY. The same ratio of primary care physicians—

Mrs. COLLINS. To patients in traditionally underserved areas as those in other communities. You mentioned that—

Mr. SPIVEY. Well, I hope we do better all around because I don't think primary care physicians have been in adequate numbers anywhere, so I am not quite certain of the intent of the question.

Mrs. COLLINS. Well, I tell you, I am still trying to get at the same thing, quite frankly and that is at the moment you don't have—you haven't been able to put your network completely together.

Mr. SPIVEY. Correct.

Mrs. COLLINS. You are hoping to do something on the west and south sides of Chicago?

Mr. SPIVEY. Yes.

Mrs. COLLINS. And yet in order to do that, it would seem to me you would want to know to some extent the ratios of primary care practitioners you want to have for the people that you already have

and those you hope to get in expanding your network in the west and south sides.

So I just wonder if you have sort of any goal. The goal of primary care, it would seem to me, would help you determine the location in those two different communities where you would want to be.

Mr. SPIVEY. Let me just say as we—I think each of us up here have looked at both our physicians presently on our staff as well as every medical group in Chicago. Now, that is not a surprise because everybody is doing that.

We are actively attempting to enhance the number of primary care physicians in our present institutions as well as looking at those institutions throughout Chicago that would have primary care physicians in more adequate numbers than most of them have.

If you look at most of the community hospitals in Chicago, you will find that the $\frac{2}{3}$ - $\frac{1}{3}$ is a pretty good rule of thumb, so it is not—it is not unusual to find that same proportion in a community hospital as well a tertiary care hospital.

We are attempting to augment the primary care in every organization that we are going to be associated with.

Mrs. COLLINS. Let me just ask you a question, Mr. Risk. How would the EHS Health Care be affected in a take-all-comers universal coverage environment if your competitors did not do the same; that is, if your competitor networks contracted only with facilities and providers located in more affluent, nonminority areas where people predominantly have health insurance?

Mr. RISK. Congresswoman, I would—I was interested to hear Dr. Henikoff's comment about the way that Medicaid would be handled under the Health Security Act which was something which I was not aware of.

Assuming that is correct, I would guess we will have a significant disadvantage because, as you can appreciate, when you run a large complex organization like all four of those that are in front of you, you worry about the continuing economic viability, and with EHS specifically, we have historically run our three hospitals in the suburban area with some degree of profitability and we have suffered some fairly sizable losses at our two hospitals in the Chicago area, and we try and balance off the gains in the suburbs with the losses in Chicago in terms of relocating capital.

To the extent that an organization like EHS would suffer a loss in what I would call full-pay patients or patients who are covered under a reimbursement formula, that is significantly better than the Medicaid reimbursement formula, then our ability to retain our physicians, our ability to continue to attract qualified clinical personnel, high-quality nurses, what have you, our ability to maintain our facilities in terms of the caliber of equipment and technology that we would need to provide the appropriate level of care to our patients I would anticipate would potentially be diminished over time.

Mrs. COLLINS. Mr. Ferguson, I am back to you again and your statement. You mentioned that you worry about the transition period during the phase-in period during which many health care providers, doctors, and hospitals who have been in the trenches de-

livering care to the underserved population community may not be adequately supported.

Talk to me about the transition period. First of all, do you think the transition period as written in the bill is long enough, or what do you think would be a sufficient transition period and what do you think should go on during that transition period?

Mr. FERGUSON. Well, my understanding and you can correct me if I am wrong, with the transition period is a transition toward more private sector providers providing care to the indigent population, that there is an assumption that there will be less need for public sector providers such as the county or the Chicago Department of Health and others since everybody is insured and so there will be a willingness to take care of the population.

I am not sure we, first of all, believe that this so-called transition is a good thing to happen for reasons I stated about continued inadequate reimbursement and a lack of desire to serve these vulnerable populations.

In fact, if I might just add one thing, you know, currently we in the county are undergoing a significant expansion of our community-based clinics in these neighborhoods you are referring to—Englewood or Austin or Woodlawn—and I don't know of any other organizations certainly doing it to this scale that we are doing it and very few are doing it at all.

So there is an avoidance of providing primary care in those communities. I don't see that changing necessarily, under health reform.

If, in fact, there is nevertheless going to be a transition and there will be a downsizing of public sector providers, then I think there is going to be a lot more attention that is going to need to be paid to assuring that the private sector providers will invest resources in those communities.

As Dr. Henikoff was saying about the Medicaid reimbursement, there may be providers in health plans willing to capture those lives because of the reimbursement associated with them. That doesn't mean necessarily that they are going to provide the necessary services to that population. There may be an avoidance of that and that in fact has been the history for the Medicaid and indigent population.

So I think we are just concerned that there is not enough attention being paid to assuring that without the public sector there as the safety net provider that the private sector will in fact provide adequate services.

Mrs. COLLINS. Thank you.

Well, Mr. Ferguson, in your testimony you mentioned that you are examining options for a managed care system and you say options ranging from a county-operated HMO to a joint venture with an existing system to contractual relationships with many systems.

Now, what advantages for Cook County and for its potential business partners would there be for these options?

Mr. FERGUSON. Well, we realized that there has been a continued movement toward more individuals being enrolled in managed care systems. This is likely, we believe, to accelerate in Illinois.

There is already talk about enrolling the Medicaid population in a managed care system. Medicaid populations are a sizable per-

centage of the people we serve. If they are forced into being enrolled in a managed care system, then we have to respond to that.

We have to make a decision internally: Well, are we going to perform our own HMO so we can continue to provide care to this population or are we going to contract with other HMO's to provide such a service? So it is a strategic decision we have to think about.

Under national health reform, if the Clinton proposal is successful, we believe that most of the currently medically indigent will also enroll—by necessity be enrolled in HMO type organizations. So again our primary target population that we serve is likely to be pushed into managed care arrangements.

We need to therefore either become such an organization ourselves and create our own vertically integrated delivery system and potentially form our own HMO or figure out ways where we can work with existing HMO's to contract with them to serve their captured lives.

Mrs. COLLINS. Well, Dr. Henikoff, you already have sort of an HMO in Anchor; is that right?

Mr. HENIKOFF. That is correct.

Mrs. COLLINS. What would be the advantages of each of these options from Rush Prudential's point of view: perhaps options ranging from a county—well, not from a county operated, but from an operated HMO where you have to have a joint venture with an existing system, to contractual relationships with other systems, if any? Would there be any?

Mr. HENIKOFF. Well, you know our HMO is an insurance product, so as an insurance product, it is in competition with other insurance products. It does contract with multiple different providers. The Rush System is not the only provider to the Rush Prudential plan.

Now, it may turn out as things evolve and the Rush System gets that extra hospital or more, that when we are—when we are geographically comprehensive in the Chicago area, then the Rush System may be the only provider to the Rush Prudential insurance mechanism, but today that is not so.

So that insurance mechanism uses multiple providers around the city and anywhere where we don't have coverage, we will use another provider. We have pretty good coverage on the west side of Chicago. We don't have good coverage on the south side of Chicago, and we are looking at doing something about that.

Mrs. COLLINS. OK. Under the reform system as detailed as the President's plan, would Rush Prudential engage in outreach to essential community providers within its service area to invite them to contract with Rush Prudential, Dr. Henikoff?

Mr. HENIKOFF. The answer is yes.

Mrs. COLLINS. On what basis would you decide with which essential providers to contract?

Mr. HENIKOFF. Now, you have to understand, you are asking me to speak for a company that I am not an officer of or a member of the board of and that is Rush Prudential. It is distinct from Rush. So it is difficult for me to speak—

Mrs. COLLINS. So what I will do, I will ask them in writing to submit it for the record and not hold you fully responsible, but from what your knowledge is, if you want to put it on the record,

fine, if not, I will write and ask them and they can put it in the record.

Mr. HENIKOFF. My understanding is how Rush Prudential chooses to contract with providers where it does not have coverage through the Rush System, it does so looking at the provider who will provide the best care at the least expense.

They are very concerned about expense because they are out in the competitive marketplace. They are also concerned about quality because that is how people buy their health care, both on cost and quality.

So my answer is that if there is a geographic hole that must be filled, there has to be coverage in that area, they will contract with the provider who gives the best care at the least expense.

Mrs. COLLINS. Thank you, very much. We touched on a number of interesting issues that are going to be raised as we continue to work through this legislation. And I would like to ask any of you if you have anything further you want to add for the record that we haven't been able to cover up to now.

Why don't we start with you, Dr. Spivey.

Mr. SPIVEY. Well, I think the reality of this next year is going to determine very much how health care in this country will be delivered. And I do hope that your committee and, as very important as your subcommittee and the entire committee on energy and commerce is, as it looks through the options available to it, takes into account some of the information that is now coming out.

I think the President's goals are most appropriate and what we want to do is build on the things that work and change the things that don't, and I do think that the challenge that you will have during this coming year is a very, very substantial and significant one, and I wish you well in it because it is important for not just those of us who are providers but everybody in this country.

Mrs. COLLINS. Thank you.

Dr. Henikoff.

Mr. HENIKOFF. Yes. I just tend to make two general comments about the task, as Dr. Spivey said, that you have before you.

As I have looked at the Health Security Act, there are two large trade-offs that have to be judged in my mind. One is in order to control total expenditure in the private sector, the requirement—and I am talking about global budgets—the requirement of the bureaucracy in the system is huge. People have estimated between 70 and 100 new Federal agencies in that bureaucracy and the question is, is the payoff worth the bureaucracy on the global budget issue?

Then we have the universal coverage issue and there is no question universal coverage is probably the most important goal of anybody's health care plan. The question is how one achieves universal coverage in the best fashion for this country, and I don't pretend to have the answer.

But in the various proposals, there are different trade-offs of costs of one kind or another, mandates of one kind or another in order to achieve universal coverage and to me that is the other great judgment that has to be made. What is the best way to go about obtaining universal coverage and the best tradeoff to make in order to obtain it.

And I am watching the evolution of this process at your level and trying to understand the judgments that are being made in these two major trade-offs.

Thank you.

Mrs. COLLINS. Thank you.

Mr. Risk?

Mr. RISK. I would echo Dr. Henikoff's words in that I believe that the President is correct when he sets as a goal for health reform that we provide universal coverage as opposed to universal access. They are two very different concepts.

The other thing that I am very concerned about is the potential amount of bureaucracy that may be created in the process of implementing this specific piece of legislation.

I sit as a member of the Governor's Health Reform Task Force in Illinois and one of the subcommittees that I was part of, the Access Subcommittee, looked at what Illinois would have to do in order to put in place the necessary levels of review in order to be in compliance with the proposed legislation.

And I think all of us were surprised at how complex a job it is and how much additional layers of decision-making would go in place and the costs of that are going to be enormous, and those are costs that are not going to necessarily add to increased quality of care or increased accessibility of care.

Mrs. COLLINS. Mr. Ferguson?

Mr. FERGUSON. Thank you. I would like to make one or two points. I think there is an important distinction that needs to be made that is interestingly brought out in your hearings here.

You wanted to focus on how we can assure that health plans can provide for the needs of vulnerable populations, the currently underserved communities.

You know, there is an important difference between how care has been delivered in the past and I think it is being proposed through the Clinton plan and other plans. You know, we have community hospitals, we have community health centers, other organizations, primarily not-for-profits, that are set up to serve a particular community in need. And many of those hospitals and health centers are in these underserved areas, and it is important that they have that focus of serving the community.

I think under a managed care system, we move away from that model toward one of providing care to a set of enrolled patients, captured lives, so to speak, so there is less of a community focus. I think it is a particularly worrisome trend when it comes particularly to these underserved areas.

It might work fine in a more middle-class suburban sort of area, but I think in these more vulnerable communities, there do need to be institutions that have a community focus.

So there is this trend and I think it is codified in the Clinton health plan toward this movement away from everybody having the residents of a particular neighborhood or a community to providing resources to the captured lives and managing that utilization.

The other trend that is occurring and I think will accelerate with the Clinton health proposal is the prominent role that for-profit insurance companies and health plans will play. Again there is a

movement away from a community server not-for-profit approach to a for-profit system of care which is going to have to be more concerned with bottom-line shareholders and board of directors than with assuring that the health standards of the residents of a community are taken care of.

So kind of to sum that up, those two concerns I have about this move away from communities and toward a for-profit system of care, I think if the managed competition model is passed into law, we will see an increase in health plans that are dominated by for-profit insurance companies and that we will therefore need to make sure that there is adequate funding and that it remains for not-for-profit organizations, be they community hospitals and also public sector providers, because there will be strong incentives by those organizations, the for-profit insurance companies and health plans, to underserve those vulnerable populations in those currently underserved communities.

Mrs. COLLINS. Well, we thank you, very much for your testimony. It certainly is helpful to us as we continue hearings on this very complex issue that we are working on in Washington, DC.

Let me say this, that in addition to this Subcommittee on Commerce and Consumer Protection and Competitiveness, also within the Energy and Commerce Committee we have Henry Waxman who is the chairman of the Health and Environment Subcommittee, which deals primarily with Federal insurance, Medicaid, Medicare and things of that nature. We have been conducting a series of joint hearings together in Washington, however, not in our districts.

We will provide, once we get our hearing record done, we will provide him and everybody else in the Congress with a copy of our hearing record from today's hearing and we will be working in concert in trying to do the best we can with the information that we have as to your thoughts and the thoughts of hundreds and hundreds of other people throughout this Nation who have a very definite major role to play as we try to get this legislation moving and try to do the best we can for all the people.

Mr. Dingell, the chairman of the Energy and Commerce Committee has said we have to have all of our work done by March 4th, which is galloping upon us, as you may know. I thought I would pass it to you so you have some idea of why we are moving so urgently.

I know today is Valentine's Day. That is why I wore my red to signify that, but I want to thank all of you for coming today. We very much appreciate it and this panel has now concluded its business.

Thank you.

Mrs. COLLINS. Our next panel will consist of Mr. Benn Green-span, the president of Mount Sinai Medical Center, Ms. Madelynne Brown, the assistant director of insurance for the State of Illinois, and Mr. William McNary, the legislative director to Illinois Public Action.

Won't you come forward, please.

Let me remind you, I think all of you were in the room when I mentioned that we are under House rules because this is a full Congressional hearing and that means that each of you will be

given 5 minutes to make a summary of your written statement with the full knowledge that your entire written statement will be made a part of the record.

Probably during the questioning and answer session much of what you probably would have wanted to say in your written statement will come out anyway, but do know that your full statement will be made a part of the record.

We are going to begin with you, Mr. Greenspan. We also have here a 1-minute thing. We have a timer that we don't ordinarily use. The timer we usually use makes a bell sound. Everything is on bells now, your computer and everything else, but this is a silent timer. So when 4 minutes have expired, Brad is going to make himself useful with that. OK.

Thank you, Mr. Greenspan.

STATEMENTS OF BENN GREENSPAN, PRESIDENT, MOUNT SINAI HOSPITAL MEDICAL CENTER; MADELYNNE L. BROWN, ASSISTANT DIRECTOR, ILLINOIS DEPARTMENT OF INSURANCE; AND WILLIAM McNARY, LEGISLATIVE DIRECTOR, ILLINOIS PUBLIC ACTION, ACCOMPANIED BY JOHN D. CAMERON, ASSOCIATE DIRECTOR

Mr. GREENSPAN. Good morning, Madam Chairwoman. I am Benn Greenspan, president of Mount Sinai Medical Center of Chicago.

I would like to thank you for the opportunity to testify today on the impact of the formation of health networks as proposed under the Health Security Act and access to care in underserved communities.

Mount Sinai Hospital Medical Center is a 469 bed teaching hospital providing primary, secondary, and tertiary care on the west side of Chicago. We are part of a system that includes rehabilitation care and extensive primary care as well as health service in the inner city.

Our institution is nationally regarded as the model of commitment to and success in inner city America. For decades we have been the leader in the development of primary care networks, medical group practice, and satellite ambulatory care centers. The network of federally qualified health centers which we founded is the largest in the State of Illinois.

Mount Sinai is a winner of the prestigious James Brown IV Award from the Chicago Community Trust and in 1992 became the only hospital in Illinois ever to win the American Hospital Association/Baxter Corporation National Foster McGaw Prize for community service.

Mount Sinai today is also one of the largest providers of care to low-income patients in the State of Illinois. Fewer than 5 percent of our patients come under the heading of commercially insured.

The communities that Mount Sinai serves are a microcosm of this Nation's urban social and health care problems. These are costly problems to confront. Maternal and infant health are not the only significant health problems of the underserved members of our society. Nonetheless, in our community while the rest of the country was experiencing an infant mortality of 8 deaths per 1,000 of births, the rate in our community went well above 20. More than

⅓ are to adolescents and 85 percent to single mothers. Costly problems to care for.

Morbidity and mortality due to violence is one of the greatest public health problems we see at Mount Sinai. Health status in general is very poor in our community.

There is no question that the health needs of our community and communities like it throughout the country are great and there is no question that the residents of these communities will benefit from the comprehensive range of services that the health care networks will provide. What is in question today, however, is whether the residents of these communities and providers who have demonstrated the commitment and expertise to provide care in these neighborhoods will be desirable to the networks that are now forming in anticipation of competition in health care reform.

Rather than summarize my written testimony today, I want to offer you an insight to the inevitability of failure that we are likely to encounter if we rely on the development of competitive model networks to essential care to communities like ours.

An essential element of free market economic theory is that resources follow demand. Remember, demand, which was cited in earlier testimony, is an economic concept relating to who wants something and who can pay for it, it is not equivalent to need. In our fee-for-service environment, the history of health care for the underserved is replete with proof that underpayment for this service to one segment of the population inevitably results in the migration of health care resources, professional, physical, and financial, toward the other segments of the population. It is certainly no mystery that institutions like Mount Sinai are under financed, spend more money to achieve acceptable staffing, and suffer a more costly burden of operating aging under capitalized facility.

In the first place, inner city hospitals cannot gain access to capital with the same freedom of mainstream institutions. Since such places generally don't have endowments and don't generate surpluses necessary to replace equipment and facilities, they must borrow to stay even. This immediately increases the cost of the operating. Institutions like Mount Sinai which were forced to borrow at times when interest rates were 10, 12, 14 percent. At this point we cannot refinance that debt as a result of the bad credit rating that inexorably follows caring for the indigent. Again, this results in increased cost of operating.

Second, with the exception of those who are extraordinarily dedicated, professionals do not readily come to work with underserved people. There are often problems of safety and crime. There is the problem of diagnostic and treatment equipment that is often a generation older than that which can be found in more economically desirable areas. All of these barriers mean that merely to maintain a first class medical capability means working harder to find people willing to work for fewer rewards, or often ante-ing up and paying many of the specialists who would otherwise work voluntarily in institutions where patients pay better for their care. Non-physician staff often must be paid additional compensation to come into this setting. Additional services, like transportation and security, must be offered in order to make the patient care environment accept-

able to patients and staff. All of these commitments add to the cost of actually delivering the patient's care.

Third, the patient care rendered in underserved and indigent communities must compensate for years of neglect and significant social and environmental burdens that are placed upon them in the community. I am astonished to hear that Medicaid and Medicare can be more efficient and less costly. Our experience is quite the opposite. People need more service to achieve the same outcomes. They represent the greatest statistical risk of having a bad or costly outcome. They are lacking the social support to allow basic assistance when they are ready for discharge to home. Greater cost and, in all likelihood, less reimbursement to the network of providing scare to these people. In our community this is a problem.

In the managed care vision of health care networks, we will continue some of the effects of unequal payment, but we will lose the continuing commitment to DSH proportionate share compensatory payment that recognizes the cost of the serving indigent community, and the only real solution will be to mainstream the commitment to those communities, what we all desire. It means full and equal incorporation of institutions like ours and their work into the large networks that emerge. If, however, those networks are going to be formed to compete for patients on the basis of cost and payment, we will once again be confronted with significant incentives to avoid the institutions serving those patients and those communities which most need the support that is to be had through such affiliation.

Under the current proposals, institutions in the inner cities will not only remain undesirables, but will lose the support that we have gained in the disproportionate share programs of the existing system.

What, then, must national health reform include to assure the viability of health care in the inner city and the inclusion of our communities in health networks. We have several specific recommendations.

First, automatic essential community provider status must be extended to those hospitals providing the highest volume of service to low-income patients and providing necessary services, such as trauma care, high-risk maternity care, and ambulatory care.

Second, health reform must include guaranteed access on the basis of need, to capital funds, loan guarantees, and direct loans for these institutions.

Third, adequate funding must be made available for health care providers serving the special needs of large numbers of low income and uninsured patients.

Fourth, disproportionate share funding must be maintained throughout the entirety of any transition period to health care reform and cannot be phased out until such sources, such as the Vulnerable Population Adjustment, are well established.

Madam Chairwoman, as an organization providing care for a very large portion of the indigent and underserved members of your district, I would like to thank you on their behalf for this opportunity to testify.

Mrs. COLLINS. Thank you.

[The prepared statement of Mr. Greenspan follows:]

Testimony Before the Subcommittee on Commerce, Consumer
Protection, and Competitiveness

Benn Greenspan

President/Chief Executive Officer

Mount Sinai Hospital Medical Center of Chicago

Madam Chairman and Members of the Subcommittee, I am Benn Greenspan, president of Mount Sinai Hospital Medical Center of Chicago. I would like to thank you for the opportunity to testify today on the impact of health networks as proposed under the Health Security Act and access to care in underserved communities.

Mount Sinai Hospital Medical Center is a 469 bed teaching hospital that provides primary, secondary, and tertiary care on the West side of Chicago, in one of the poorest communities in the state. Mount Sinai today is one of the major providers of care to low income patients in the state of Illinois. Fewer than 5% of our patients are commercially insured. Over 50% of our patients are covered by Medicaid, and an additional 20% are covered by Medicaid HMOs. Mount Sinai is also one of the major providers of free care in Illinois. 8.5% of our care, amounting to \$10 million a year, is free care. We are proud that we maintain our commitment to provide care to all patients who come to our doors, regardless of their ability to pay.

The communities that Mount Sinai serves are a microcosm of this

nation's urban social and health care problems. These areas are predominantly African-American and Latino, with poverty rates ranging from 38% to 53%. While the rest of the country was experiencing an average infant mortality rate of 8 per thousand, the infant mortality rate in our community was higher than 20 deaths per thousand. Nearly one third of the births in the community are to adolescent mothers - and up to 85% of the births in many of our communities are to single mothers. The percentage of low birthweight infants is 50% higher than that for the state as a whole.

Maternal and infant health are not the only significant health problems of the underserved members of our society. Health status, in general, is very poor in these communities. Death rates from heart disease, cerebrovascular disease, and cancer are more than double those in the rest of the state. Death rates due to homicide, cirrhosis, diabetes, hypertension, pneumonia, injuries, and firearm incidents are all extremely high. Morbidity and mortality due to violence is one of the greatest public health problems we see at Mount Sinai.

There is no question that the health needs of our community, and communities like it, are great. There is also no question that the residents of these communities would benefit from the comprehensive range of services that health networks can provide. The residents of these communities deserve the same quality and level of service

that is available in more affluent areas. It is, however, questionable whether the residents of these communities, and the providers which have demonstrated commitment and expertise in providing services to meet the intensive health needs of these neighborhoods, will be desirable for the competitive model networks that are now forming in anticipation of health care reform.

What I would like to discuss in my testimony are three points: the importance of maintaining access to services within inner city communities; the current barriers to including these communities in networks; and the elements that must be mandated in health care reform to ensure that these communities have access to a full range of services.

Universal coverage is not the same as universal access. We believe that access to health care in these communities cannot be guaranteed unless we ensure that the institutions and medical personnel needed to provide care remain in the community. We strongly applaud the intention of the Health Security Act to provide universal coverage of health care. Effective access to care is dependent on having providers who are located within a community, are committed to serving this patient population, who are culturally sensitive to the needs of the community, and who have the resources and programs that are necessary to provide the range of services that actually reach and address our patients needs. It has also been demonstrated over and over again that,

when the institutions which provide inpatient care leave a community, it is not just hospitals that disappear. Jobs, nurses, and primary care are devastated. We therefore start with the premise that, if networks are to effectively provide care in inner city neighborhoods, that care should be given by the providers that have demonstrated through mission, location and historical experience the ability to serve these patients.

Mount Sinai is one such a provider. We have gained national recognition for the range of community based health care we provide, and we have learned to operate and survive with limited resources. However, our experience at Mount Sinai provides an illustration of the barriers to inclusion of these communities in networks of care. By most measures, Mount Sinai should be a desirable part of a major health network. Mount Sinai already has in place a comprehensive range of health care services, from community based primary care to the highest level of tertiary care and rehabilitation services.

Mount Sinai has eighteen affiliated primary care sites. Through our ambulatory care programs, Mount Sinai provides 250,000 outpatient visits a year. Our nationally known community health program includes thousands of visits in support services and case management, particularly in the area of maternal and child health.

Mount Sinai is a Level III perinatal center, the highest level

certified in the state, providing care to high risk infants. Mount Sinai is one of four remaining Level I trauma centers in Chicago, providing trauma care to over 2,000 patients a year. In addition, Mount Sinai provides over 39,000 emergency room visits a year. The demand for many of our services exceeds our current ability to provide them. For example, we currently deliver approximately 3,500 babies a year at Mount Sinai. We are over capacity in maternity services, and know that there is demand for at least another 1,000 deliveries a year.

Mount Sinai is also the primary provider of mental health services in our community, with programs including community mental health, home psychiatric care, and a psychiatric day facility. Mount Sinai also operates a major home health care agency. Mount Sinai is a permanent affiliate of Schwab Rehabilitation Hospital and Care Network. Schwab has 85 inpatient rehabilitation beds and has over 1,200 admissions a year. Schwab has six ambulatory care sites, provides 40,000 outpatient visits a year, and is a center for head trauma care, spinal cord injury treatment, and pediatric rehabilitation.

Mount Sinai's market share in its service area is second only to Cook County Hospital. Mount Sinai is also one of the most cost effective teaching hospitals in Chicago. Our occupancy rates have been consistently among the highest in Illinois.

This combination of factors - an existing primary care network, comprehensive services, market penetration, high occupancy, and low cost, should make us an attractive partner in any network hoping to serve our community. However, at this point in time, we are not considered desirable or sought after by any of the emerging network.

The reasons for this exclusion, I believe, lie less in the decisions of the individual networks, and more in the systemic problems of inner city health care that national health reform must address. I believe there are major barriers. The first is uncertainty regarding reimbursement for services provided to patients currently covered by Medicaid, those who are uninsured and those who will remain uninsured even after health reform. The second is the outstanding bill for deferred capital improvements that has resulted in a decaying health infrastructure in the inner city. The third barrier is that, even with coverage, many of these patients will remain undesirable to many institutions. Any new system that institutionalizes two tiers of payment and two tiers of care will continue to motivate many providers to steer clear of low income patients.

Over the last decade, care for Medicaid and uninsured patients in Illinois has increasingly become concentrated in a small group of hospitals. Those of us who serve a disproportionate number of Medicaid and uninsured patients have been without a stable,

reliable source of funding. We have been unable to predict the level of our reimbursement from year to year. Many institutions have yet to recover from the years of ICARE, a contracting program in Illinois that financially devastated many inner city hospitals. In addition, the State of Illinois no longer covers medical services for patients formerly covered by General Assistance. It is not surprising that the negative financial implications of these policies have been enormous. Mount Sinai's cumulative loss for the period from 1983-1991 was over \$14 million.

Over the last two years, funding for Medicaid services, particularly for disproportionate share hospitals, did improve. However, as recent events in Illinois have demonstrated, this funding remains unstable, and Medicaid providers are threatened with substantial and potentially devastating cuts in reimbursement. In addition, although the Clinton health care plan recognizes the need to support institutions serving large numbers of low income patients, the funding level proposed for that support remains inadequate. In addition, even the Clinton plan does not provide coverage for the many undocumented immigrants we currently serve. In this reimbursement climate, it is not surprising that large networks view many inner city hospitals as poor financial risks.

The capital infrastructure crisis that faces many inner city institutions is a direct result of this chronic underpayment. The only way that Mount Sinai, and other hospitals like us across the

country, survived financial instability was to defer necessary capital improvements. Our own financial standing, and the instability of state funding, has made it very difficult for us to obtain access to debt financing. Our most recent analysis of our physical plant demonstrates the need for over \$50 million in capital improvements. Surveys by the National Association for Public Hospitals have demonstrated that our situation is far from unique. No network in a competitive model, driven by price competition, will willingly assume this level of capital needs without assurances that the financial infrastructure of these institutions will be supported.

What, then, must national health reform include to assure the viability of health care in the inner city and the inclusion of our communities in health networks. We have several specific recommendations.

First, automatic essential community provider status should be extended to those hospitals meeting the greatest commitment to services for low income patients and providing necessary services, such as trauma care, high risk maternity care, and ambulatory care. With essential community provider status, there must be a five year guarantee that these institutions must be included in health networks.

Second, health reform should include capital access assistance for

capital funds, loan guarantees, and direct loans for these institutions. The National Association for Public Hospitals has proposed a capital initiative for inclusion in the Health Security Act.

Third, adequate funding should be made available for health care providers serving large numbers of low income and uninsured patients. The special needs of these populations require extraordinary investment in personnel, services, security and transportation. While the President's proposal recognizes the need for such funding through the Vulnerable Population Adjustment, the amount currently proposed is inadequate.

Fourth, disproportionate share funding must be maintained through any transition period to health care reform and cannot be phased out until as other sources, such as the Vulnerable Population Adjustment, are well established and adequate. Disproportionate share recognizes not only the costs of treating uninsured patients, but also the costs associated with the level, scope, and intensity of services that are essential to the survival and resurrection of these communities.

Finally, we must recognize that the system will respond to the health needs of these communities adequately only if positive incentives are mandated in health reform. I would like to thank the Committee for this opportunity to testify.

Mrs. COLLINS. Ms. Brown.

STATEMENT OF MADELYNNE BROWN

Ms. BROWN. Good morning. I am Madelynne Brown. I am the assistant director of insurance of the State of Illinois. Let me begin that I—

Mrs. COLLINS. Would you pull your mike a little bit closer?

Ms. BROWN. Let me begin by thanking you for inviting us here today and commending you on your foresight in this huge undertaking: Health care reform.

The National Association of Insurance Commissioners and the Illinois Health Care Reform Task Force have been considering the question of health care reform for several years.

The Department of Insurance is an active member of both of these groups. NAIC representatives have testified before Congress on this issue on numerous occasions. We have followed with great interest the debate on President Clinton's proposal. Given the extent of the debate at this time and the fact that the Illinois task force is deliberating, our opinions must be qualified and kept in the context of the great unknown.

We make this point now because we believe we have much practical experience to offer your subcommittee, particularly as the direction of health care reform becomes clearer. Today we can provide you with an overview of what we believe any oversight agency must be able to have in terms of responsibility and authority if it is to regulate full availability of quality health care to all. We also can give you a historical perspective on managed care.

Currently, the Department of Insurance's responsibility for the regulation of managed care plans allowed by Illinois law is primarily in the area of financial responsibility and policy forms. Our role is to assure that these plans have the financial ability to keep the promises they make to consumers.

We have very limited legal authority to regulate health standards for managed care plans. In an attachment to the written testimony, we have outlined the regulatory authority for health standards and managed care plans.

We do have data on the location the of health maintenance organizations in general and those which operate through independent provider associations. We have provided you with maps showing that the greatest concentration of HMO's in Illinois is in the metropolitan Chicago area.

Last year, Illinois enacted small group reform legislation which included requirements for portability of coverage and community rating. Legislation was also enacted that requires insurers to accept standardized claim forms.

The Illinois Health Care Reform Task Force is currently exploring a variety of issues and these include the expansion of portability and the formation of pooling mechanisms for small businesses.

It is important that while we are looking at reforms in the regulatory arena that we do not overlook needed reforms to the Employee Retirement Income Security Act. As you know, ERISA removed the regulation that the—of health insurance provided to many Americans from the States.

The Department of Insurance does not regulate self-insured plans. The result is that the largest part of the health care financing market, the large employer, is unregulated and in many instances the employee is unprotected.

The State insurance department regulates less than 30 percent of health care provided to consumers. We are primarily working with the NAIC in anticipating and planning for changes in the regulation of health care. There is a general consensus that regardless of the eventual form of the system, regulation will be needed in the following areas:

Unfair trade and claims practices, consumer assistance and complaints, continuity of access, licensing of companies, licensing of agents, audits of financial condition and performance, policy form compliance, data collection, and confidentiality issues and fraud.

We will provide you with more detail of these issues in our written testimony, and I do want to thank you for your attention.

Mrs. COLLINS. Thank you.

[Testimony resumes on p. 301.]

[The prepared statement of Ms. Brown follows:]

Madelynnne L. Brown
Assistant Director of Insurance
State of Illinois

INTRODUCTION

Good morning, Madame Chairwoman and Members of the Subcommittee; my name is Madelynnne Brown. I am the Assistant Director of Insurance of the State of Illinois.

Let me begin by thanking you for inviting us here today and commending you on your foresight in this huge undertaking: health care reform. The National Association of Insurance Commissioners (NAIC) and the Illinois Health Care Reform Task Force have been considering the question of Health Care Reform for several years. We are active members of both of these groups. NAIC representatives have testified before Congress on this issue on numerous occasions. We have followed with great interest the debate on President Clinton's proposal. Given the extent of the debate at this time and the fact that the Illinois Task Force is deliberating, opinions must be qualified and kept in the context of the great unknown.

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care to all. We also will have a historical perspective on managed care.

Currently the Department of Insurance's responsibility for the regulation of managed care plans allowed by Illinois law is primarily in the area of financial responsibility and policy forms. We have very limited legal authority to regulate health standards for managed care plans.

Last year, Illinois enacted small group reform legislation which included requirements for portability of coverage and community rating. Legislation also was enacted that requires insurers to accept standardized claim forms. The Illinois Health Care Reform Task Force is currently exploring a variety of issues. These include the expansion of portability and the formation of pooling mechanisms for small businesses.

It is important that while we are looking at reforms in the regulatory arena, we not overlook needed reforms to the Employee Retirement Income Security Act (ERISA). As you know ERISA removed the regulation of the health insurance provided to many Americans from the states. We do not regulate self insured plans. The result is that the largest part of the health care financing market, the large employer, is unregulated and in many instances, the employee unprotected.

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We are primarily working with the NAIC in anticipating and planning for changes in the regulation of health care. There is a general consensus that regulation will be needed in the following areas: unfair trade and claims practices; consumer assistance and complaints; continuity of access; licensing of companies; licensing of agents; audits of financial condition and performance; policy form compliance; data and confidentiality and fraud.

We will cover the above subjects in more detail in the balance of this testimony.

DEVELOPMENT OF MANAGED CARE PLANS AND THEIR REGULATION

Illinois law provides for several different managed care arrangements. Attached is a chart which outlines regulatory authority for health standards for these managed care plans. (Attachment A) The Department of Public Health has most authority for HMOs. That authority does not include service area authorization. Only in Medselect is there a broad grant of authority.

Voluntary Health Service Plan Act - In June of 1951, Illinois made its first in-road into the arena of managed care with the legislature's passage of the Voluntary Health Services Plans Act. This Act enabled a health care plan to enter into contracts with physicians and hospitals for the rendering of care to its members. It introduced the idea that the provision of medical services should be based upon their being medically necessary. The General Assembly saw fit to encourage the development of these programs by providing statutory relief from the potential of malpractice liability and minimum benefit mandates. They did, however, require the review of premium rates, established minimum financial thresholds, and imposed maximum caps on how much these corporations could charge for administrative solicitation expenses. Illinois' legislature charged the Department of Insurance with every aspect of regulation, except that of health standards oversight.

Under this new and innovative model, a modest handful of managed health care plans developed. Several plans formed to exclusively cover members of its work force. Others formed as extensions of Chicago based hospitals, including Michael Reese and Rush. This approach represented a marked departure from the insured indemnity market in which the insured was free to go to the provider of his choice and the reimbursement of medical care was limited only by traditional policy exclusions and benefit caps.

Only 12 of these plans remain and no new ones can be formed.

Health Maintenance Organization Act - Approximately twenty years later, Illinois enacted the Health Maintenance Organization Act. This new standard required organizations to provide a minimum of health care services called "basic health care" and further required that all such care be provided through contracted providers. HMOs were given the authority to contract with physicians and hospitals of their choice; thereby enabling the creation of Illinois' first closed panel or exclusive provider network. The HMO Act was a logical evolution from the previous Voluntary Plans Act. Its passage brought with it the conversion of the majority of those health plans originally formed under the Voluntary Act.

Since enrollees no longer had free choice as to what doctor, clinic or hospital they could use, the legislature deemed it both desirable and necessary to regulate the accessibility, availability and quality of care provided. This responsibility was

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delegated to the Illinois Department of Public Health. All such regulatory activities are currently conducted by that agency.

There are currently 37 licensed HMOs in Illinois, with a statewide enrollment of approximately 1,700,000 members. Eighty-seven percent of those members are located within Cook and the collar counties, with an average of 18 HMOs servicing each county. This is in contrast to 3 HMOs per county for all other areas in the state covered by HMOs. There are 22 downstate counties which are not currently serviced by any health maintenance organization. Attached is a map showing the distribution of HMOs throughout the state. (Attachment B)

HMOs are generally characterized by the type of network through which they deliver care such as Staff, Individual Practice Association (IPA), Network, Group and Mixed and Physician Hospital Organizations. The majority of HMOs in Illinois, as well as on a national basis, provide care through an IPA model plan. IPAs are those entities which contract with medical practitioners for the delivery of health care services.

Attached are two maps which indicate areas of penetration of HMOs with IPAs. The first map (Attachment C) shows the number of Individual Practice Associations (IPAs) which have contracts with HMOs. You will note that of the 259 IPAs having contracts with HMOs, 244 (94%) are found within Cook and the contiguous counties. The second map (Attachment D) is a subset of the first and shows a

more detailed view of the Chicago area. The zip code areas which are not served by any IPA are shown in white. This does not necessarily mean that these areas are not served by any HMO since there are other model types which could be operating in these areas or the area could be business rather than residential.

Health Care Reimbursement Act - As the effectiveness of a contracted provider network manifested itself, insurers began investing in health maintenance organizations. They found that many of the managed health care techniques, which worked so well in HMOs, also worked in the insurance arena. The concepts of medical necessity, second opinions, pre-certification, and utilization review were effective mechanisms in containing costs.

However, one part of the managed care puzzle was missing - a contracted network of providers. Illinois' Insurance statute prohibited insurers from contracting with "preferred" providers. This impediment was removed in 1985 when the Health Care Reimbursement Act was created. Insurers could now contract with "preferred" providers and provide incentives for insureds to use their services. Insureds were still free to see the provider of their choice, but were provided financial incentives, in the form of lower deductibles and copayments, to use network providers.

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In this act, our Department is charged with registration of those preferred provider administrators (PPA) which are not licensed insurance companies, and with oversight of certain fiduciary and bonding requirements for those registered PPAs who handle money. PPAs subject to the Act must, in their registration, attest to the availability and accessibility of care. They also must have a program of utilization review and contract on an equal basis with all providers which are able to meet their terms and conditions.

Illinois currently has 77 registered PPAs which have preferred networks covering physician, hospital, medical surgical, dental, vision and pharmaceutical services.

Licensed insurance companies can also form PPAs and since the passage of the Health Care Reimbursement Act, the Department has approved approximately 140 separate insurance policies, containing preferred provider options, from 80 different insurers. Seventy-five percent of these contracts contain major medical PPO network options. The remaining policies cover services such as dental, vision, pharmaceutical and a handful of hospital/surgical programs.

This would appear to point toward the general accessibility of a comprehensive array of health care services. These services are available through the mechanism of a network care, resulting in greater coverage and lower costs for the consumers of Illinois.

Limited Health Service Organization Act - In 1989, the managed care market further evolved to include "single service" HMOs. The Limited Health Service Organization Act was formed to permit the marketing of a dental, vision, pharmaceutical, podiatric or emergency care plan. The regulation of these plans is similar to that of health maintenance organizations except that the Department of Public Health does not review availability, accessibility or quality of care. The General Assembly now requires plans licensed under this act to provide, to the Director of Insurance, an attestation that care is available, accessible, and will provide for continuity of treatment.

To date, there are 8 Limited Health Service Organizations (LHSOs). The scope of care provided by each is limited to dental coverage. One LHSO has obtained additional authorization, required under the Act, to provide a vision care plan. No hospital or "major medical" type plan can be provided under this Act.

Medicare Select - The last significant change to managed care came with the passage of the Omnibus Budget Reconciliation Act of 1990 (OBRA-90). On and after the effective date of this act, all states had to conform to strict standards with respect to the benefits, loss ratios, disclosure and solicitation of Medicare supplement policies. Further, the federal mandate put a moratorium on any Medicare supplement policy which contained a preferred provider provision unless that state passed additional standards relating to benefits and care provided through network providers.

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These new standards regulate a managed care Medicare supplement called Medicare Select. In September of 1993, Illinois received such certification from HCFA. Illinois does not currently have any pending or approved policies under this program.

Consumers today also have the ability to compare medicare supplement policies and to shop around for the best deal. Prior to the NAIC developing and implementing standardized packages this was a difficult, if not impossible, task.

RECENT ILLINOIS HEALTH CARE REFORM ACTIVITY

The Illinois Health Care Reform Task Force consists of a distinguished group of Illinois experts from the public and private sectors, in the health care area. It was established by the Governor in November, 1992 to tackle major health care issues confronting state government. The Task Force, through its committees, has begun to address a wide range of broad issues including among others financing, malpractice reform, long term care, managed care and access.

Currently the Task Force is focusing on two priority areas identified in Governor Edgar's recent state of the State Address. The first area is that of insurance "portability": the provision of a continuity of affordable insurance coverage for those Illinoisans who are between jobs. The second area is the desirability of establishing a mechanism to assure that small businesses have access to affordable health insurance.

Uniform Claim Form and Small Employer Rating, Renewability and Portability Insurance Act - On July 13, 1993, Governor Edgar signed into law Senate Bill 830, which became Public Act 88-84. The purpose of this Act was twofold.

First, SB 830 required the Director of Insurance to meet with various industry and health care representatives for the purpose of developing uniform and simple insurance claim and billing

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forms. A task force of approximately 29 members, representing the insurance industry, HMO industry, Illinois Hospital Association, Illinois State Medical Society and the Illinois Dental Society was assembled. The Uniform Claim and Billing Task Force met three times in an effort to draft a rule, using the NAIC Model as the basis for Illinois' proposal. The end product of the Task Force requires insurers to accept designated claim forms for hospital, physician and dental services. The group's recommendations were formalized into Rule 2017 and the first notice was published in the Illinois Register on January 3, 1994. The Act and thus the Rule do not apply to providers so they are not required to use the standardized claim forms.

The second part of the Act was designed to improve the efficiency and fairness of the small group health insurance marketplace by preventing abusive rating practices and establishing rules for continuity of care. Because of emerging questions as to the intent and interpretation of various sections, the Department established a forum to air pending issues and formulate corollary positions. A twelve member panel, representing interested parties, was formed on November 10, 1993. The work of the group in conjunction with the Department resulted in the development of a question and answer sheet, designed to provide guidance on key issues. Once completed, the document was sent to all HMOs and A&H carriers licensed in Illinois.

ERISA PROBLEMS

The Employee Retirement Income Security Act (ERISA) of 1974 was intended to allow certain groups great flexibility in providing employee benefits without the need to comply with state regulatory requirements or with state mandates. There were generally no requirements to pay premium taxes or contribute to guaranty funds. Self-funded health plans are virtually free to operate without any meaningful standards or oversights.

While the theory was sound - remove costly mandates and regulations, therefore lowering costs, the reality is that some less than honorable persons have exploited the exemption and with no oversight have bilked consumers with "fly-by-night" operations. Our Department, as well as most other insurance departments, have had numerous experiences with these type of operations which have left a substantial number of consumers with substantial unpaid claims and no coverage.

Some problems the NAIC and the member States have had with ERISA are:

- . ERISA does not require self-funded health plan administrators to submit plan disclosure documents to any administrative agency for review;

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- . ERISA allows the plan administrator of a self-funded health plan to delay distribution of a summary of material modifications to the plan for up to 210 days after the end of the plan year in which the changes are adopted;
- . ERISA prohibits consumers from bringing suit in state court alleging common law fraud and negligent misrepresentation about coverage under a health plan governed by ERISA;
- . ERISA preempts state mandated benefit laws and thereby prevents states from applying these laws to self-funded health plans;
- . ERISA provides participants with no protection from unilateral and discriminatory termination of benefits, exclusions;
- . ERISA provides no assurance that participants will receive timely and understandable disclosure of the terms and operation of their health plan coverage, deprives participants of any state court remedy if they are misled, and allows the most crass manipulation of the terms of health plans at the expense of participants and their children or dependents;

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- . ERISA preempts a state cause of action for "managed care malpractice," but does not itself provide an administrative remedy for negligent or intentional malfeasance in the administration of managed care plans. The only recovery ERISA allows is a recovery of plan benefits.

ERISA Market Reforms that take place in the course of reforming the health care system should do several things to assure that consumers are protected in terms of market conduct.

- . Recognize that "accountable health care plans" act as insurers and that they should be subject to regulation as such;
- . Clearly delineate the agencies that are responsible for the regulation of "accountable health care plans";
- . Ensure that both insured and self-funded health benefit plans conform to specified standards;
- . Ensure that insured and self-funded plans provide clear and understandable disclosure of the terms of the plan;
- . Prohibit discriminatory termination of benefits by amendment to the health plan or allow for specification of the benefits which must be provided under a health plan by statute, regulation or a designated party;

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- . Require "portability," i.e., prohibit insured and self-funded health plans from denying coverage of preexisting health conditions after a participant changes coverage from one plan to another;
- . Ensure that entities that perform utilization review, pre-authorization review, or claims adjudication functions for insured or self-funded health plans are subject to performance standards and compliance enforcement and auditing;
- . Encourage the application of quality control measures to insured and self-funded health plans; and
- . Provide appropriate protection for the privacy and confidentiality of individually identifiable participant information.

FUTURE REGULATORY ISSUES

We believe that consumer protection is an essential ingredient that must be considered in any health care reform. Market Conduct is a major consideration for consumers as they choose between the various plans. In some cases they will or should be given information to assist them and other times they will rely on the regulatory oversight agency to protect them. In either instance, the oversight agency must be granted appropriate authority.

Unfair Trade Practices - The Unfair Trade Practices Acts goes to the heart of the redlining issue, i.e. discrimination. The acts generally go to fair marketing practices, fair advertising practices, fair underwriting practices, etc. Specifically in the context of health care reform the Act could be tailored to address items such as medical necessity, utilization review and even provider networks.

Unfair Claims Practices - This Act can define what improper actions constitute improper claims practices. Generally the acts spell out time frames for performance; e.g. respond in 20 days; and give rules of conduct; e.g. explain the reasons for any denial. This can require notification of the availability of the regulatory agency and even set out procedures for responding to complaints.

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Data Requirements - There needs to be a general understanding early on that there will be a continuing need to study what is going on in the areas of marketing, underwriting, claims and procedures. Certain standards for data capture should be looked at now with an eye to the kind of studies we want to perform. In Illinois the standardized claim form is statutory but only goes to insurers, not providers.

Licensing - Every health care alliance and provider network should be licensed. The litany of requirements go to the character, qualifications, competency and financial ability to perform. This area must include various prerequisites for licensure and also standards for performance. In this section there is generally the penalties for non-performance, e.g. suspension or revocation of license.

Policy Form - The regulatory oversight agency needs to have sufficient authority to allow and/or disallow certain policy contracts. The contract is where the promise for future performance occurs. This promise should be straight forward and should not be ambiguous or misleading. The agency should also be a library of sorts for all forms. When there is a coverage dispute, retrieval of the correct form is essential. An appropriate database is essential. Technology allows for paperless files and electronic filing, which should be accommodated.

Health Care Purchasing Alliance Model - The Illinois Department has been working extensively with the NAIC to establish a regulatory framework regarding health reform. Ultimately the NAIC plans to develop two alternative models. The first will be a voluntary alliance model which we hope will be completed by June, 1994. The second model is the mandatory alliance model which should be ready by December, 1994. This model assumes that there would be waivers from the provisions of ERISA. Without some form of waiver or change in the law, state initiatives would be prohibited.

Quality and Accountability - The NAIC is working on model standards in each of the following areas: quality assurance, utilization management, grievance procedures, credentialing, provider contracting, confidentiality, data reporting, and accessibility standards. It is important that although there may be many types of payers and plans, including health maintenance organizations, preferred provider organizations, point-of-service plans, fee-for-service plans, Blue Cross and Blue Shield plans, commercial indemnity plans and other related organizations, that all consumers are properly protected under a structured system of regulation.

HEALTH STANDARDS FOR MANAGED CARE PLANS

	HMO	LHSO*	MEDSELECT	PPA
Regulatory Agency	IDPH	IDOI	IDOI	IDOI (Registration Only)
Statute	215 ILCS 125/2-	215 ILCS 130/2002	215 ILCS 5/363	215 ILCS 5/370f
Regulation	240.10 - 120	None	2008.73	None
Availability	x	x	x	x
Accessibility	x	x	x	x
Promptness of Care			x	
Travel Time			x	
After-hour care			x	
Number & type of providers			x	
Appropriateness of referrals			x	
Emergency Care			x	
Continuity of Service	x	x	x	
Quality of Assurance	x	x	x	
Description of Structure			x	
Utilization Review	x	x	x	x
Provider Contracts	x	x	x	
Prohibited Provider Billing			x	
Provider Description by Specialty			x	
Quarterly Update of Providers			x	
Non-discrimination among providers				x
Service Area			x	
Approval			x	
Service Area Maps			x	
Number of Plans		37	8	0
Effective Date of Act	October 1, 1974	September 1, 1989	September 24, 1993	September 19, 1985

* All LHSOs currently offer only dental benefits, except for one company which has the additional authorization to offer vision care services.

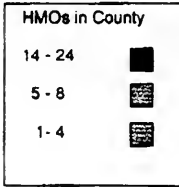
Definitions

HMO	A health maintenance organization provides a comprehensive array of health care services through contracted providers.
LHSO	A limited health service organization provides a single service through contracted providers. Services are limited to dental, vision, pharmaceutical, podiatric and emergency.
MedSelect	A Medicare Select policy offers Medicare supplement benefits through a restricted provider network.
PPA	A preferred provider administrator arranges, contracts with, or administers contracts with preferred providers, where the member is provided an incentive to use the services of such provider.

Attachment A

File Update - 02/10/94

Illinois HMOs - Demographic Distribution by County

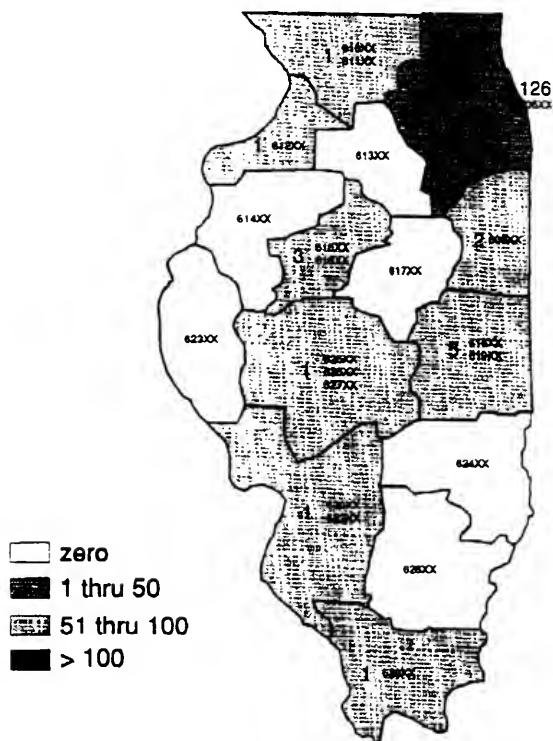


- Illinois population 11,543,000
- State HMO enrollment 1,672,490
- Chicago HMO enrollment 1,442,861
- State HMO penetration 16%
- Chicago HMO penetration 13%

Attachment B

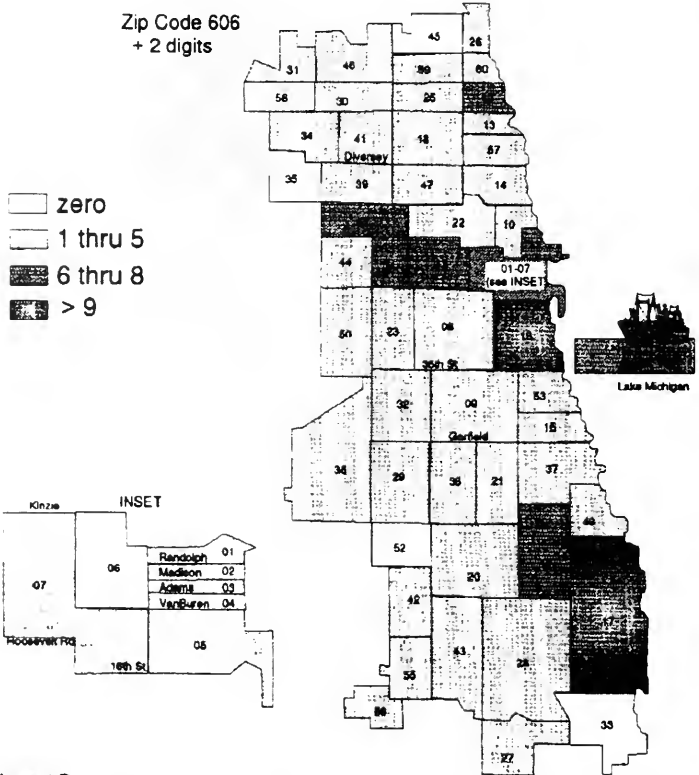
Source: Illinois Department of Public Health, November, 1981

*Number of Provider Sites
within 3 digit zip code areas*



Source: Illinois Department of Insurance, February, 1994 IPA Report

Number of Provider Sites within Chicago 5 digit zip code areas



Attachment D

Source: Illinois Department of Insurance, February, 1994 IPA report

Mrs. COLLINS. Mr. McNary.

STATEMENT OF WILLIAM McNARY

Mr. McNARY. Madam Chairwoman, my name is William McNary. I am the legislative director for Illinois Public Action. I am joined by our associate director, John Cameron.

On behalf of Illinois Public Action, I would like to thank you for the opportunity to express our views today on the issues involved in health reform, the growth of provider networks and their implication for consumers in the Chicago metropolitan area.

As you are aware, we have witnessed a rapid spread of provider networks in recent years, a trend that has accelerated with the prospect of significant Federal health care reform. The major proposals at the center of congressional health debate, including President Clinton's Health Security Act and Representative Cooper's Managed Competition Act, H.R. 3222, propose a central role for such networks in the future delivery of health care services.

From the consumer perspective, however, the growth of such networks raises very serious questions regarding access to care in urban neighborhoods. Two, fair access to coverage for consumers in those communities, as well as the adequacy of proposed—three, of proposed oversight of consumer protections, each of which I will briefly address here today.

Most of the development of provider networks has been initiated in the Chicago area by the city's largest and most prestigious hospitals, several of which have testified here this morning. However, for consumers in many of Chicago's urban neighborhoods, health care services are most frequently delivered through the multitude of smaller community hospitals.

These institutions provide a disproportionate share of the medical care for low-income families, those dependent on Medicaid or Medicare for their coverage, and those without any insurance coverage at all.

Needless to say, these are not plum acquisitions for a provider network that is organized to maximize the amount of money coming in and restrict the amount of money going out. Many of these institutions already suffer severe financial problems and Federal policies designed to favor the delivery of care through provider networks will do little to address the crisis they face in keeping their doors open while serving a very needy community.

In fact some policies such as the Health Security Act's proposed elimination of disproportionate share funding for Medicare payments to such facilities would make it significantly harder for such institutions to survive. Curtailing existing support for such hospitals will do nothing to ease the health care crisis in Chicago's communities.

Even for those community hospitals that are incorporated into larger regional networks there will be a constant bottom-line pressure to consolidate facilities and to scale back or eliminate the services they now provide.

For example, Bethany Hospital on the west side has teetered on the brink for several years. Currently it is part of the EHS health system which has made a commitment to keeping the facility operating. Yet in the intensified competitive environment projected by

the Clinton and Cooper proposals, it is very hard to imagine how such a commitment could be maintained.

If it becomes official policy to view hospitals as profit-oriented actors engaged in aggressive competition for market share rather than as nonprofit institutions to deliver health services, many community hospitals now serving Chicago's urban neighborhoods will be placed in serious jeopardy.

To its credit, the President's bill recognizes the special needs of urban communities that are underserved. If a State chooses to pursue the single-payer option under his plan, it can negotiate budgets and reimburse community hospitals directly based on their need and patient loads.

If a State chooses the health alliance option, the regional health alliances are clearly mandated to assure that facilities exist to provide sufficient care in underserved communities.

By contrast, under the Cooper plan, States have no such options nor are there effective protections to assure that the forces of managed competition do not squeeze out community hospitals that cannot compete effectively.

Access to coverage. As part of the Health Security Act, coverage for all Americans would become automatic. Under both the single payer and the health alliance options, States would be required to cover the costs of services for every citizen or legal resident alien.

However, the health alliance option would provide for that coverage through a variety of privately run competing health plans which would vary in cost and networks of participating providers. Such plans would be operated on a for-profit basis, presumably by insurance companies and/or provider networks.

The delivery of coverage through such a proposal would mark significant departure from the current system. Individuals, rather than employers, would choose their health carriers.

The health coverage market that would emerge would be much more similar to that of the property/casualty field where individuals choose their own provider of home and auto insurance.

While the President has stressed the virtue of such an individual choice, it also has a potentially negative effect for lower-income consumers in urban communities. Under his approach, there would be strong incentives for and, we believe, the likely emergence of discriminatory marketing by health carriers, much like the redlining that now occurs in the auto and homeowner insurance markets.

The difficulty to administer individual cost-sharing requirements, the complicated subsidies for lower-income families, and the fewer opportunities to sell more expensive coverage would render low-income families and lower-income communities much less desirable for the private plans. The current trend towards marketing health services to affluent and suburban consumers would be enhanced.

The Clinton bill recognizes these dangers and mandates that health alliances assure such redlining does not occur. However, statutory prohibitions against discrimination have had limited effectiveness in other fields of insurance, especially when discriminatory behavior is strongly rewarded by financial gain.

Finally, both the Clinton plan and the Cooper bill raise key questions about the enforcement of consumer safeguards.

Under the single-payer option, the State's primary concerns would be with those of medical quality and the relationship between the provider and the consumer. These are critical questions and the Clinton proposal establishes numerous initiatives to allow the consumer to make informed choices on quality issues as well as to assure that providers are making appropriate decisions.

I would like to elaborate on that in further questions and answers.

In closing, I want to again thank you, Madam Chairwoman, for your leadership on health reform issues particularly as they affect consumers and urban communities.

Based upon our testimony this morning, I am sure that it is clear to you that consumers have a strong interest in the outcome of the health reform battle. As we have noted, the Cooper plan will have very negative consequences for access to care and the quality of coverage provided by urban consumers.

The President's Health Security Act could be quite problematic in terms of maintaining access to care through community hospitals in the equal and nondiscriminatory access to quality coverage through these private health plans, and through adequate enforcement of consumer rights.

However, the Health Security Act's provision of the option for single-payer plans at the State level is the significant strength of this bill. As a cosponsor of Representative McDermott's single-payer Federal plan, the American Health Security Act, I know you also recognize the advantages of this approach from the consumer standpoint.

We trust that you will fight diligently to assure that States retain the single-payer option in any plan that passes Congress.

Thank you.

Mrs. COLLINS. Mr. Greenspan, under a health system reformed along the lines of the President's proposal, what would be the consequences for your hospital not being invited to become part of a health plan or provider network? Would you be operating at a disadvantage and would it affect the level or quality of service that you are able to provide?

Mr. GREENSPAN. Madam Chairwoman, Mount Sinai Hospital currently provides more than \$10 million a year in totally unreimbursed free care to individuals who have no source of payment. This is not the difference between charges and what is paid, this is care to individuals with no coverage.

Unless Mount Sinai and other hospitals like it are assured of a continuing flow of support for care for those individuals in society who are excluded by any category from coverage, unless institutions like ours have the network of support Mr. Risk talked about earlier that allows the capitalization for primary care growth and for replacement of facilities, our survival is ultimately questionable.

We are faced today as we sit here with old debt, for example, that costs us more than \$.5 million a year in interest rates that are in excess of what is currently market competitive interest rates, which makes our care expensive, makes it untenable in the competitive marketplace.

We are faced with specialty needs. Inner city populations do not gain access to specialists like ophthalmology, ENT, orthopedic sur-

gery. And unless one has the support of a network providing those services guaranteed throughout the network, they become increasingly scarce.

If networking is going to be the modality of care, it must be equally and fairly available to all residents of our country and our city.

Mrs. COLLINS. Ms. Brown, the Department of Insurance has responsibility for registration of preferred provider administrators or PPA's.

Now, to what extent do you review, during that process, the locations of providers within such an arrangement and the number of patients that a PPA is designed to serve in each part of the town or city?

Ms. BROWN. Madam Chairwoman, the registration requirement is that the providers when they register give us certain information and attest to that certain information. There is no requirement—we don't have the authority to approve where they have placed providers, so we examine what they have given to us, but we can't question whether—where they have placed a provider.

Mrs. COLLINS. Well, you had the responsibility to register the PPAs, though, right?

Ms. BROWN. Right. We register them in terms of—the registration statute calls for us to take attestations to certain things, but we don't really have the authority to question or to approve or disapprove where they put the location. This is a registration for not a—

Mrs. COLLINS. So you won't be a player at all in trying to determine whether or not these PPA's, any of these PPA's are going to be in underserved communities?

Ms. BROWN. I can't address that in terms of the future act. I can only address that in terms of the Illinois statute today.

Mrs. COLLINS. And as of right now, the answer is no?

Ms. BROWN. Right.

Mrs. COLLINS. OK. Thanks.

Your testimony added that PPA's "... must contract on an equal basis with all providers which are able to meet their terms and conditions."

Now, the question is: to what degree are PPAs required to engage in outreach to providers in different parts of town if you don't have any requirements for them? I don't understand this.

Ms. BROWN. The requirement is that they are to set out what their terms and conditions are. Any provider who can meet those, they have to accept that provider.

The statute does not require that they go out and seek out the providers. They have to promulgate their requirements for a provider and any provider who can meet those requirements, they have to accept and they have to pay.

Mrs. COLLINS. Would a PPA be able to solicit participation of providers who they would like to include within their own networks?

Ms. BROWN. Would they be able to solicit?

Mrs. COLLINS. Yes.

Ms. BROWN. There is nothing that I am aware of that would prevent them from soliciting, but there is nothing also that requires them to.

Mrs. COLLINS. So there is no requirement for outreach and solicitation is allowed even if done on a picking-and-choosing manner that could have discriminatory implications; is that right?

Ms. BROWN. Right this minute there is no requirement and there is no prohibition.

Mrs. COLLINS. No prohibition either. OK.

You stated also that "Illinois currently has 77 registered PPA's", and since 1985, "The Department has approved approximately 140 separate insurance policies containing preferred provider options from 80 different insurers."

Would you be able to tell us where the bulk of Chicago area providers participating in this group are concentrated?

Ms. BROWN. I can't. No. I don't have that information with me today. I am sorry.

Mrs. COLLINS. Well, that is a question I am asking now, and I would ask you to provide that information for us within 5 working days, if you will, please.

Mrs. COLLINS. Following your statement on HMO's and PPA's, you concluded that these programs translate to "general accessibility" of health services, "... resulting in greater coverage and lower costs for the consumers of Illinois."

To reach that conclusion, it seems that you must have looked quite closely at them and have been satisfied with the accessibility of greater coverage, not just for some select Chicago neighborhoods, but for all of the neighborhoods.

Could you tell us, please, and describe it for us how you reach this conclusion with respect to residents of Chicago's west and south sides?

Ms. BROWN. From the information that we have in terms of the locations of the HMO's in the State of Illinois, the majority of HMO coverage is around the Chicago area. Go down State, you have much less.

We have got statistics that show that there is a provider location in virtually every zip code in the city of Chicago. It is connected with an HMO.

Mrs. COLLINS. Wouldn't the reason for that be because you have a larger population in Chicago than you might have in other cities or towns in Illinois?

Ms. BROWN. Chicago has a larger concentration of citizens, yes, but there are also a significant number of citizens of Illinois otherwise and the disparity between the distances that a citizen in down State might have to travel to get to an HMO is much greater than that in the city of Chicago.

Mrs. COLLINS. You have a larger number of HMO's in Chicago. What about PPA's?

Ms. BROWN. I am not certain about PPA's.

Mrs. COLLINS. Would you provide us with that information as well?

Ms. BROWN. Yes.

Mrs. COLLINS. Would you also break it down as to the west side and south side of Chicago?

Ms. BROWN. I will break it down to west side and south side of Chicago in that—if we have that information in our records.

[Testimony resumes on p. 328.]

[The following information was received:]



STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD, ILLINOIS 62767

OFFICE OF THE ASSISTANT DIRECTOR

February 23, 1994

The Honorable Cardiss Collins
Chairwoman
Subcommittee on Commerce, Consumer
Protection and Competitiveness
U. S. House of Representatives
Washington, D.C. 20515-6120

Re: Additional testimony

Dear Representative Collins:

Attached is additional testimony to supplement the testimony I gave at your field hearing on February 14, 1994.

During this hearing on the Clinton Health Care Reform bill you requested that the Department of Insurance provide you with any additional information we have on provider networks. We are supplying you with the information we have received in required registrations and filings.

Questions were raised during the hearing about the role of the department in consumer protection. Included in the additional testimony is a brief overview of the Department's duties, responsibilities and accomplishments.

I would like to reiterate that the Department of Insurance, if given authority to regulate health care standards including location of providers as a result of health care reform legislation, will vigorously take all actions necessary to protect the citizens of Illinois.

Very truly yours,

Madelynn L. Brown

Madelynn L. Brown
Assistant Director of Insurance

MLB:dj

cc: Jim Schacht
Mark Peterson
Brad Kane

**Supplemental Testimony of
the Illinois Department of Insurance
Before the Subcommittee on Commerce, Consumer Protection and Competitiveness
of the
Committee on Energy and Commerce
of the
United States House of Representatives**

Provider care - Accessibility and Availability

Introduction

Health care in the State of Illinois is made available through four basic types of mechanisms: ERISA or self-insured groups, insurers, health maintenance organizations and preferred provider administrators. The federal government has pre-empted all state regulation of ERISA activities. The Illinois Department of Insurance's regulatory role is summarized as follows:

ERISA or Self-Insured Groups

The Illinois Department of Insurance has no authority to regulate self-insured plans. According to the Self-Insurance Association of Illinois, approximately 78% of the group market is self-insured. This is a national figure, but we have been informed by the association that this figure is equally applicable to the Illinois group market. This figure can be broken out into the following: 1) 50% of the plans with fewer than 1000 employees are self-insured and 2) 80% of the plans with 1000 or more employees are self-insured.

Insurers

Preferred provider networks, administered by insurers are not subject to the PPA registration requirements of the Health Care Reimbursement Act. The Act specifically excludes insurers from the definition of "Administrator".

Included as Attachment I is a listing of insurers with preferred provider arrangements. The Department of Insurance is required to compile and maintain this information. It is important to note that the attachment only indicates those insurance companies that have filed health insurance contracts which make use of a preferred provider network. It does not mean that any contracts were actually issued, or if issued, are still in force.

Health Maintenance Organizations

The scope of the Department's regulation is limited to activities specific to the business of insurance. The Illinois Department of Insurance does not have statutory authority with respect to the regulation of accessibility or quality of care issues. This function is performed solely by the Illinois Department of Public Health. Attached to the Department's testimony before the Subcommittee on Commerce, Consumer Protection and Competitiveness on February 14, 1994, were maps which reflected provider distribution on both a statewide and Cook County basis.

Preferred Provider Administrators (PPAs)

The Illinois Department of Insurance does not have the statutory authority to regulate accessibility and availability of preferred providers. The Health Care Reimbursement Act is a registration statute; therefore, we do not have authority to require physicians, clinics or hospitals to conduct business within specific geographic areas. Included as Attachment II is a listing of all Illinois registered preferred provider administrators. Forty-five percent of the PPAs in the attachment have included Cook County as a part of their service area.

Department Functions

The Illinois Department of Insurance (IDOI) is the administrative agency of state government charged with regulating the insurance industry and protecting the lawful rights of Illinois insurance consumers. Key to this mission is monitoring the financial solvency of all regulated entities through enforcement of the Illinois Insurance Code, the Illinois Pension Code and related laws and regulations.

The Department's regulatory mandates are carried out through a number of programs including: analysis of the financial statements of all licensed companies, fraternal organizations and public employee pension funds established in the state; periodic financial and market examinations of insurance companies; examination and licensing of insurance producers; review and approval of policy forms; rate regulation; investigation of consumer complaints; preparation of new legislation; and hearings on complaints and violations of the Illinois Insurance Code.

Consumer Assistance

Year End 1993 information

- Investigated 13,292 written complaints; providing relief to over 50% of the complainants.
- Responded to 70,000 telephone inquiries
- Reviewed 28,346 Property & Casualty form and 3,200 rate filings
- Reviewed 19,468 Life/A&H and 1,116 HMO policy form filings
- Year end 1992 - Conducted 49 Market Conduct Examinations. Findings include:
 - \$57,753 in premium overcharges
 - \$48,882 in claim underpayments
 - \$72,250 in civil forfeitures
 - Six Stipulation and Consent orders
 - Eighteen Filing orders
 - Twenty-seven examination results pending for 1993
- Processed 85,117 Producer licenses
- Conducted 604 Producer Regulatory examinations. Findings include:
 - 65 Revocations
 - 93 Stipulation & Consent Orders
 - \$127,750 in Civil Forfeitures

Department Functions - cont.***Financial Regulation***

Year End 1993 information

- ♦ Completed analysis of 664 financial statements
- ♦ Conducted 44 comprehensive Life/A&H financial reviews and 32 actuarial examinations
- ♦ Completed 96 Property & Casualty examinations including 82 comprehensive, 7 compliance and 7 special/targeted
- ♦ Thirty-three companies have been assigned to the Regulatory Action Section, resulting in 2 orders of conservation, rehabilitation or liquidation

Legal Activities

Year End 1993 information

- | | |
|---------------------------------------|-----|
| ♦ Administrative Hearings | 116 |
| ♦ Civil/Administrative Cases | 11 |
| ♦ Regulatory files reviewed | 451 |
| ♦ Rules initiated | 12 |
| ♦ Rules Adopted | 10 |
| ♦ Subpoenas processed | 26 |
| ♦ Freedom of Information Act requests | 162 |

Public Pensions

Year End 1993 information

- | | |
|--------------------------------|----|
| ♦ Issued Warrants | 87 |
| ♦ Completed Field Examinations | 67 |
| ♦ In-process examinations | 29 |

FILE UPDATE 02/03/94

INSURER BASED PREFERRED PROVIDER ARRANGEMENTS

RECORDS AS OF SEPT. 1985

312

1	NAME	ADDRESS	CITY	STATE	ZIP	FILED NO.	APPROPRIATE	COV./TYPE	ADMINISTRATOR REFERENCE
1	ACTINA LIFE INSURANCE COMPANY	1517 ARMBURG AVENUE - MC33	HARTFORD	CT	06156			MAM	PARTNERS NATIONAL HEALTH PLANS
2	ACTINA LIFE INSURANCE COMPANY OF ILLINOIS	151 ARMBURG AVENUE	HARTFORD	CT	06156			MAM	SELF
3	ACTINA LIFE INS. CO.	151 FARMINGTON AVE.	HARTFORD	CT	06156			PHC	TAKE CARE ADMINSTRATIVE SERVICE CORP.
4	ALLIANCE LIFE INSURANCE CO. OF NORTH AMERICA	1750 HENNEPIN AVE. SOUTH	MINNEAPOLIS	MN	55403-2195			MAM	SELF
5	ALLIANCE LIFE INSURANCE COMPANY	ALLSTATE PLAZA	NORTH BROOK	IL	60062			MAM	AMERITAS LIFE INS. CORP.
6	ALLIANCE LIFE ASSUR. CO. OF FL.	11222 OUAL ROOST DRIVE	MIAMI	FL	33157-6596		ABL-01	PHC	AMERITAS LIFE INS. CORP.
7	AMERICAN HERITAGE LIFE INS. CO.	AMERHER LIFE BLDG; ELEVEN E FOURTH ST	JACKSONVILLE	FL	32202			PHC	AMERITAS LIFE INS. CORP.
8	AMERICAN HERITAGE LIFE INSURANCE COMPANY	ONE MOODY PLAZA	DALVESTON	TX	77550-7999			MAM	EFFICIENT HEALTH SERVICES, INC. (EHS)
9	AMERICAN NATIONAL INS. CO.	ONE AMERITAS WAY, P.O. BOX 81889	DALVESTON	TX	77550-7999			MAM	EFFICIENT HEALTH SERVICES, INC. (EHS)
10	AMERITAS LIFE INSURANCE CORP.	ONE AMERITAS WAY, P.O. BOX 81889	DALVESTON	TX	77550-7999			MAM	EFFICIENT HEALTH SERVICES, INC. (EHS)
11	AMERITAS LIFE INSURANCE CORP.	ONE AMERITAS WAY, P.O. BOX 81889	DALVESTON	TX	77550-7999			MAM	EFFICIENT HEALTH SERVICES, INC. (EHS)
12	BANKERS LIFE & CASUALTY COMPANY	4444 WEST LAWRENCE AVENUE	CHICAGO	IL	60630-1501			MES	HEALTH FIRST NETWORK
13	BANKERS LIFE & CASUALTY COMPANY	4444 WEST LAWRENCE AVENUE	CHICAGO	IL	60630			MES	HEALTH FIRST NETWORK
14	BANKERS LIFE & CASUALTY COMPANY	4444 WEST LAWRENCE AVENUE	CHICAGO	IL	60630			MES	HEALTH FIRST NETWORK
15	BANKERS LIFE & CASUALTY COMPANY	4444 WEST LAWRENCE AVENUE	CHICAGO	IL	60630			MES	HEALTH FIRST NETWORK
16	BANKERS LIFE & CASUALTY COMPANY	4444 WEST LAWRENCE AVENUE	CHICAGO	IL	60630			MES	HEALTH FIRST NETWORK
17	BANKERS LIFE & CASUALTY COMPANY	4444 WEST LAWRENCE AVENUE	CHICAGO	IL	60630			MES	HEALTH FIRST NETWORK
18	BANKERS LIFE & CASUALTY COMPANY	4444 WEST LAWRENCE AVENUE	CHICAGO	IL	60630			MES	HEALTH FIRST NETWORK
19	CLINTON LIFE ASSURANCE CO. OF AMERICA	215 WEST WALKER DR. SUITE 700	CHICAGO	IL	60606-5303			MAM	HEALTH FIRST NETWORK
20	CENTENAL LIFE ASSURANCE COMPANY	5300 METCAL - P.O. BOX 470	CHICAGO	IL	60606-5303			MAM	HEALTH FIRST NETWORK
21	CENTENAL LIFE ASSURANCE COMPANY	5300 METCAL - P.O. BOX 470	CHICAGO	IL	60606-5303			MAM	HEALTH FIRST NETWORK
22	CHICAGO IMOLTD	510 N. LASALLE STREET	MADISON	WI	53705			PHC	HEALTH FIRST NETWORK
23	CHICAGO IMOLTD	510 N. LASALLE STREET	MADISON	WI	53705			PHC	HEALTH FIRST NETWORK
24	CHICAGO IMOLTD	510 N. LASALLE STREET	MADISON	WI	53705			PHC	HEALTH FIRST NETWORK
25	CONNECTICUT GENERAL LIFE INSURANCE COMPANY	800 COTTAGE GROVE ROAD, BOX 218	BLOOMFIELD	CT	06001			MAM	HEALTH FIRST NETWORK
26	CONTINENTAL ASSURANCE CO.	CNA PLAZA	CHICAGO	IL	60685			MAM	HEALTH FIRST NETWORK
27	COUNTRY LIFE INS. CO.	P.O. BOX 2000	BLOOMINGTON	IL	61702-2000			MAM	HEALTH FIRST NETWORK
28	COUNTRY LIFE INS. CO.	P.O. BOX 2000	BLOOMINGTON	IL	61702-2000			MAM	HEALTH FIRST NETWORK
29	COUNTRY LIFE INS. CO.	P.O. BOX 2000	BLOOMINGTON	IL	61702-2000			MAM	HEALTH FIRST NETWORK
30	COUNTRY LIFE INS. CO.	P.O. BOX 2000	BLOOMINGTON	IL	61702-2000			MAM	HEALTH FIRST NETWORK
31	COUNTRY LIFE INS. CO.	P.O. BOX 2000	BLOOMINGTON	IL	61702-2000			MAM	HEALTH FIRST NETWORK
32	COUNTRY LIFE INS. CO.	P.O. BOX 2000	BLOOMINGTON	IL	61702-2000			MAM	HEALTH FIRST NETWORK
33	COUNTRY LIFE INS. CO.	P.O. BOX 2000	BLOOMINGTON	IL	61702-2000			MAM	HEALTH FIRST NETWORK
34	EMPLOYERS INSURANCE OF WAUSAU	2000 WESTWOOD DRIVE	WAUSAU	WI	54402-8017			MAM	HEALTH FIRST NETWORK
35	EPIC LIFE INSURANCE COMPANY	2000 WESTWOOD DRIVE	WAUSAU	WI	54401			MAM	HEALTH FIRST NETWORK
36	EPIC LIFE INSURANCE COMPANY	2000 WESTWOOD DRIVE	WAUSAU	WI	54401			MAM	HEALTH FIRST NETWORK
37	FAIRBANKS LIFE ASSURANCE SOCIETY OF THE U.S.	185 BROADWAY SQUARE, P.O. BOX 328	NEW YORK	NY	10007			MAM	HEALTH FIRST NETWORK
38	FIRST MARK STANDARD LIFE INSURANCE COMPANY	200 EAST FALL CREEK BLVD	INDIANAPOLIS	IN	46205			MAM	HEALTH FIRST NETWORK
39	GENERAL AMERICAN LIFE INS. CO.	P.O. BOX 14490	ST. LOUIS	MO	63178			MAM	HEALTH FIRST NETWORK
40	GENERAL AMERICAN LIFE INS. CO.	P.O. BOX 14490	ST. LOUIS	MO	63178			MAM	HEALTH FIRST NETWORK
41	GENERAL AMERICAN LIFE INS. CO.	P.O. BOX 14490	ST. LOUIS	MO	63178			MAM	HEALTH FIRST NETWORK
42	GOLDEN RULE INS. CO.	7440 WOODLAND DRIVE	INDIANAPOLIS	IN	46228-1716			MAM	HEALTH FIRST NETWORK
43	GOLDEN RULE INS. CO.	7440 WOODLAND DRIVE	INDIANAPOLIS	IN	46228-1716			MAM	HEALTH FIRST NETWORK
44	GREAT LIFE ASSURANCE COMPANY THE	GREAT WEST LIFE CNTR, #509 E ORCHARD RD	ENGLWOOD	CO	80111			MAM	HEALTH FIRST NETWORK
45	GUARDIAN LIFE INS. CO.	1275 MILWAUKEE AVE.	GLENVIEW	IL	60025			MAM	HEALTH FIRST NETWORK
46	GUARDIAN LIFE INSURANCE COMPANY OF AM. THE	201 PARK AVENUE, SOUTH	NEW YORK	NY	10003			MAM	HEALTH FIRST NETWORK
47	HEALTH DIRECT INSURANCE, INC.	1101 EAST TOWNE AVE SUITE 500	DES PLAINES	IL	60018-2908			MAM	HEALTH FIRST NETWORK
48	HUMAN LIFE INSURANCE CO.	THE HUMAN BLDG 500 W. MAIN ST., BOX 1438	LOUISVILLE	KY	40201-1438			MAM	HEALTH FIRST NETWORK
49	HUMAN LIFE INSURANCE COMPANY	THE HUMAN BLDG 500 W. MAIN ST., BOX 1438	LOUISVILLE	KY	40201-1438			MAM	HEALTH FIRST NETWORK
50	HUMAN LIFE INSURANCE COMPANY	500 WEST MAIN STREET P.O. BOX 1438	LOUISVILLE	KY	40201-1438			MAM	HEALTH FIRST NETWORK
51	HUMAN LIFE INS. CO.	233 NORTH MICHIGAN AVENUE	CHICAGO	IL	60601-5655			MAM	HEALTH FIRST NETWORK
52	H.C.S.C.	233 NORTH MICHIGAN AVENUE	CHICAGO	IL	60601-5655			MAM	HEALTH FIRST NETWORK
53	JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY	JOHN HANCOCK PLACE, P.O. BOX 111	BOSTON	MA	02117			MAM	HEALTH FIRST NETWORK
54	JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY	JOHN HANCOCK PLACE, P.O. BOX 111	BOSTON	MA	02117			MAM	HEALTH FIRST NETWORK
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67	JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY	JOHN HANCOCK PLACE, P.O. BOX 111	BOSTON	MA	02117			MAM	HEALTH FIRST NETWORK
68	JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY	JOHN HANCOCK PLACE, P.O. BOX 111	BOSTON	MA	02117			MAM	HEALTH FIRST NETWORK
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70	JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY	JOHN HANCOCK PLACE, P.O. BOX 111	BOSTON	MA	02117			MAM	HEALTH FIRST NETWORK
71	JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY	JOHN HANCOCK PLACE, P.O. BOX 111	BOSTON	MA	02117			MAM	HEALTH FIRST NETWORK
72	JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY	JOHN HANCOCK PLACE, P.O. BOX 111	BOSTON	MA	02117			MAM	HEALTH FIRST NETWORK
73	JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY	JOHN HANCOCK PLACE, P.O. BOX 111	BOSTON	MA	02117			MAM	HEALTH FIRST NETWORK
74	JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY	JOHN HANCOCK PLACE, P.O. BOX 111	BOSTON	MA	02117			MAM	HEALTH FIRST NETWORK
75	JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY	JOHN HANCOCK PLACE, P.O. BOX 111	BOSTON	MA	02117			MAM	HEALTH FIRST NETWORK
76	JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY	JOHN HANCOCK PLACE, P.O. BOX 111	BOSTON	MA	02117			MAM	HEALTH FIRST NETWORK
77	JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY	JOHN HANCOCK PLACE, P.O. BOX 111	BOSTON	MA	02117			MAM	HEALTH FIRST NETWORK
78	JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY	JOHN HANCOCK PLACE, P.O. BOX 111	BOSTON	MA	02117			MAM	HEALTH FIRST NETWORK
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81	JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY	JOHN HANCOCK PLACE, P.O. BOX 111	BOSTON	MA	02117			MAM	HEALTH FIRST NETWORK
82	JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY	JOHN HANCOCK PLACE, P.O. BOX 111	BOSTON	MA	02117			MAM	HEALTH FIRST NETWORK
83	JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY	JOHN HANCOCK PLACE, P.O. BOX 111	BOSTON	MA	02117			MAM	HEALTH FIRST NETWORK
84	JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY	JOHN HANCOCK PLACE, P.O. BOX 111	BOSTON	MA	02117			MAM	HEALTH FIRST NETWORK
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96	JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY	JOHN HANCOCK PLACE, P.O. BOX 111	BOSTON	MA	02117			MAM	HEALTH FIRST NETWORK
97	JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY	JOHN HANCOCK PLACE, P.O. BOX 111	BOSTON	MA	02117			MAM	HEALTH FIRST NETWORK
98	JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY	JOHN HANCOCK PLACE, P.O. BOX 111	BOSTON	MA	02117			MAM	HEALTH FIRST NETWORK
99	JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY	JOHN HANCOCK PLACE, P.O. BOX 111	BOSTON	MA	02117			MAM	HEALTH FIRST NETWORK
100	JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY	JOHN HANCOCK PLACE, P.O. BOX 111	BOSTON	MA	02117			MAM	HEALTH FIRST NETWORK

COV/TYPE LEGEND: MES - MEDICARE SUPPLEMENT DEN - DENTAL MAM - MAJOR MEDICAL HSM - HOSPITAL/SURGICAL MEDICAL PHC - PHARMACEUTICAL COVERAGE VIS - VISION COVERAGE

NO	NAME	ADDRESS	CITY	STATE	ZIP	FILING NO.	APPROPRIATE	CO/TYPE	ADMINISTRATOR REFERENCE
64	MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY	1295 STATE STREET	SPRINGFIELD	MA	01111	1031L	101567	DEN	U.S. DENTAL PLANS, INC.
65	MATERNAL AND CHILD LIFE INSURANCE COMPANY	1295 STATE STREET	SPRINGFIELD	MA	01111		062087	DEN	PREFERRED CARE NETWORK, INC.
66	MEDICARE LIFE AND HEALTH INSURANCE COMPANY	500 N. W. PLAZA STREET	CLEVELAND	OH	43103		070396	MAM	SELF
67	METLIFE LIFE INSURANCE COMPANY	ONE MADISON AVENUE	NEW YORK	NY	10017		062168	MAM	METLIFE HEALTH CARE NETWORK
68	METROPOLITAN LIFE INSURANCE COMPANY	ONE MADISON AVENUE	NEW YORK	NY	10017		020687	MAM	SELF
69	METROPOLITAN LIFE INSURANCE COMPANY	4 MANHATTANVILLE ROAD	PURCHASE	NY	10576		091587	DEN	SELF
70	MUTUAL LIFE INS CO OF NEW YORK THE	MUTUAL OF OHAMA PLAZA	OMAHA	NE	68175		091896	DEN	SELF
71	MUTUAL OF OHAMA INS CO	MUTUAL OF OHAMA PLAZA	OMAHA	NE	68175		082487	MSM	SELF
72	MUTUAL OF OHAMA INS CO	MUTUAL OF OHAMA PLAZA	OMAHA	NE	68175		042887	DEN	INSURANCE DENTISTS OF AMERICA
73	NATIONAL CASUALTY CO.	ONE CITY CENTRE	ST. LOUIS	MO	63101	NCIPMO03L	032093	DEN	AFFORDABLE HEALTH CARE CONCEPTS
74	NATIONAL CASUALTY CO.	P.O. BOX 619075	ST. LOUIS	MO	63101	NGBO0869	092562	MSM	AFFORDABLE HEALTH CARE CONCEPTS
75	NATIONAL CASUALTY CO.	209 BOYLSTON STREET	DALLAS	TX	75261	STIM-180	112393	MAM	SELF
76	NATIONAL GROUP LIFE INS. CO	51 MADISON AVE	BOSTON	MA	02117		061058	MAM	RUSH CONTRACT CARE
77	NATIONAL HEALTH INSURANCE COMPANY	3321 W. BELTLINE HIGHWAY	NEW YORK	NY	10010		061768	MAM	SELF
78	NEW YORK LIFE INSURANCE CO	1750 HENRIETTA AVE	MADISON	WI	53713		011898	MAM	PREFERRED CARE NETWORK, INC.
79	NORTH AMERICAN LIFE AND CASUALTY COMPANY	1800 CHESTNUT STREET	NEWARK	NJ	07102		091587	MAM	PERSONAL CARE HEALTH MANAGEMENT, INC.
80	NORTH AMERICAN LIFE AND CASUALTY COMPANY	1800 CHESTNUT STREET	NEWARK	NJ	07102		050468	MAM	RUSH CONTRACT CARE
81	PAN AMERICAN LIFE INSURANCE COMPANY	P.O. BOX 2465	HOUSTON	TX	77252		101090	MAM	CARLE HEALTH ALLIANCE, INC.
82	PAN AMERICAN LIFE INSURANCE COMPANY	ONE AMERICAN ROW	HOUSTON	TX	77252	8003(290)	020803	MAM	NOT KNOWN
83	PHILADELPHIA AMERICAN LIFE	100 BRIGHT MEADOW BLVD P.O. BOX 1900	HARTFORD	CT	06183		052001	DEN	PHILADELPHIA AMERICAN LIFE
84	PHILADELPHIA AMERICAN LIFE	100 BRIGHT MEADOW BLVD P.O. BOX 1900	ENFIELD	CT	06082		070762	DEN	SELF
85	PHILADELPHIA AMERICAN LIFE	100 BRIGHT MEADOW BLVD P.O. BOX 1900	ENFIELD	CT	06082		060568	MAM	PRIVATE HEALTH CARE SYSTEMS, INC.
86	PHOENIX AMERICAN LIFE INSURANCE COMPANY	100 BRIGHT MEADOW BLVD P.O. BOX 1900	ENFIELD	CT	06082		022261	MAM	SELF
87	PHOENIX AMERICAN LIFE INSURANCE COMPANY	100 BRIGHT MEADOW BLVD P.O. BOX 1900	ENFIELD	CT	06082		022261	MAM	SELF
88	PHOENIX AMERICAN LIFE INSURANCE COMPANY	100 BRIGHT MEADOW BLVD P.O. BOX 1900	ENFIELD	CT	06082		022261	MAM	SELF
89	PHOENIX AMERICAN LIFE INSURANCE COMPANY	100 BRIGHT MEADOW BLVD P.O. BOX 1900	ENFIELD	CT	06082		022261	MAM	SELF
90	PHOENIX AMERICAN LIFE INSURANCE COMPANY	100 BRIGHT MEADOW BLVD P.O. BOX 1900	ENFIELD	CT	06082		022261	MAM	SELF
91	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PL090301	020963	MAM	AFFORDABLE HEALTH CARE CONCEPTS
92	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	PRIVATE HEALTH CARE SYSTEMS, INC.
93	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	RUSH-PRESSBYTERIAN-ST. LUKES MEDICAL CENTRE
94	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
95	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
96	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
97	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
98	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
99	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
100	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
101	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
102	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
103	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
104	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
105	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
106	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
107	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
108	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
109	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
110	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
111	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
112	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
113	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
114	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
115	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
116	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
117	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
118	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
119	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
120	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
121	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
122	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
123	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
124	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
125	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF
126	PIONEER LIFE INSURANCE CO OF IL	P.O. BOX 120, NORTH MAIN ST.	ROCKFORD	IL	61105	PM022101A	020963	MAM	SELF

CO/TYPE LEGEND: MES = MEDICARE SUPPLEMENT DEN = DENTAL MAM = MAJOR MEDICAL MSM = HOSPITAL/SURGICAL MEDICAL PHC = PHARMACEUTICAL COVERAGE VIS = VISION COVERAGE

INSURER BASED PREFERRED PROVIDER ARRANGEMENTS
RECORDS AS OF SEPT. 1985

ENR	NAME	ADDRESS	CITY	STATE	ZIP	FILING NO.	APPROPRIATE	COV/TYPE	ADMINISTRATOR REFERENCE
127	MUTUAL OF OMAHA LIFE INS. CO.	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175		09/15/86	MAN	SELF
128	UNITED OF OMAHA LIFE INS. CO.	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175		09/15/86	DEN	SELF
129	UNITED WORLD LIFE INSURANCE COMPANY	DODGE AT 33RD	OMAHA	NE	68175		04/28/87	MAN	RUSH-PRES. ST. LUKES HEALTH PLANS, INC.
130	WASHINGTON NATIONAL INS. CO.		EVANSTON	IL	60201	WNGP718	10/15/82	MAN	HEALTH RISK MANAGEMENT
131	WASHINGTON NATIONAL INS. CO.		EVANSTON	IL	60201	WNGP777	10/15/82	MAN	CCN INC.
132	WASHINGTON NATIONAL INS. CO.		EVANSTON	IL	60201		09/15/86	MAN	CCN INC.
133	WASHINGTON NATIONAL INS. CO.	1630 CHICAGO AVE	EVANSTON	IL	60201		08/09/88	MAN	CCN INC.
134	WASHINGTON NATIONAL INS. CO.	1630 CHICAGO AVE	EVANSTON	IL	60201		04/13/87	MAN	PRIVATE HEALTHCARE SYSTEMS, LTD
135	WASHINGTON NATIONAL INS. CO.	300 TOWER PARKWAY	LINCOLNSHIRE	IL	60069	WNGC#85	07/10/84	MAN	PREFERENTIAL CARE, INC.
136	WASHINGTON NATIONAL INS. CO.	1630 CHICAGO AVE	EVANSTON	IL	60201		04/08/87	MAN	HEALTHINK
137	WESTERN LIFE INSURANCE COMPANY	P.O. BOX 64271	ST. PAUL	MIN	55164		07/03/86	MAN	JOHN P. PEARL AND ASSOC., LTD
									SELF

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 PREFERRED PROVIDER, THIRD PARTY ADMN, THIRD PARTY PRESCRIPTION PROGRAM
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ANAME	DEDAY	EFDAY
ADMAR CORPORATION EDWARD EVANS 1551 N TUSTIN AVE SANTA ANA CA 92707	870123	930101
AFFORDABLE HEALTH CARE CONCEPTS INC % HEALTHCARE COMPARE CORP 3200 HIGHLAND AVENUE DOWNERS GROVE IL 60515	880808	930101
AMERICAN AS FOR AFFORDABLE DENTISTRY INC WILLIAM J MARICONDIA, DDS 2360 HASSELL ROAD / SUITE E HOFFMAN ESTATES IL 60195	920915	930101
ASSOCIATED DENTAL SERVICES INC DONNA K ROOS 9052 N DEERBROOK TRAIL BROWN DEER WI 53223	900828	930101
ASSOCIATION DENTAL PLAN FRED L SHARPE DDS 2121 PRECINCT LINE ROAD / SUITE 101 HURST TX 76054	930101	930101
AVESIS INCORPORATED ROY A FLEGENHEIMER P O BOX 15600 PHOENIX AZ 85060	910101	930101
BEHAVIORAL HEALTH SYSTEMS INC EDWARD W HATCH 485 S FRONTAGE ROAD SUITE 305 BURR RIDGE IL 60521-7110	870617	930101
CAPP CARE INC ROBERT L BROADBUSH WEST TOWER 4000 MAC ARTHUR BLVD /#10000 NEWPORT BEACH CA 92660-2526	360219	930101
CARLE HEALTH INSURANCE MANAGEMENT CO C CARLETON KING 602 WEST UNIVERSITY AVENUE URBANA IL 61801	880114	930101
CCN INC / FPIQUAL HEALTHCARE GEORGE MURPHY 8911 BALBOA AVENUE SAN DIEGO CA 92123	880805	930101

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ANAME	OEDAY	EFDAY
CENTERPOINT INDEPENDENT DENTISTS ASSN DONALD HEIDRICH 114 CHURCH STREET NEW LENOX IL 60451	900813	930101
CMG HEALTH OF ILLINOIS INC MARY ANN KING 25 CROSSROADS DRIVE OWINGS MILLS MD 21117	920518	930101
COMMUNITY MEDICAL MANAGEMENT SERV INC ROBERT W CARLSON P O BOX 17049 ROCKFORD IL 61110-7049	920522	930101
COMPASS PPA INCORPORATED JOHN F HARTER 310 SOUTH MICHIGAN AVE / SUITE 1300 CHICAGO IL 60604	890407	930101
COMPREHENSIVE DENTAL PLAN INC NICHOLAS C CARD M.D. 2350 EAST DEVON AVENUE DES PLAINES IL 60018	910506	930101
COMPREHENSIVE HEARING AID PLAN INC NICHOLAS C CARD M.D. 160 NORTH WACKER DRIVE CHICAGO IL 60606	910506	930101
COMPREHENSIVE PHARMACY PROGRAM NICHOLAS C CARD M.D. 2350 EAST DEVON AVENUE DES PLAINES IL 60018	900101	930101
COMPREHENSIVE VISION PLAN INC NICHOLAS C CARD 160 NORTH WACKER DRIVE / SUITE 400 CHICAGO IL 60606	861120	930101
DCA ADMINISTPATORS INC JOYCE M LENDING 462 N MILWAUKEE AVE WHEELING IL 60090	911115	930101
DENTAL CARE PLUS MANAGEMENT CORP WILLIAM W LI DDS BS 770 N HALSTED ST / SUITE 308 CHICAGO IL 60622	870611	930101

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ANAME	DEDAY	EFDAY
DIRECT DENTAL CARE DR POLLY REESE 1800 SHERMAN AVE / #517 EVANSTON IL 60201	930604	930604
EMPLOYEE HEALTH SYSTEMS INC JOSEPH M ZEREGA 17 W 727 BUTTERFIELD ROAD / SUITE E OAKBROOK TERRACE IL 60181	930318	940101
EQUICOR INC PAUL J TIDWELL 1801 WEST END AVENUE NASHVILLE TN 37203	880104	930101
FIRST COMMONWEALTH OF ILLINOIS INC CHRISTOPHER C MULTHAUF 53 WEST JACKSON / SUITE 215 CHICAGO IL 60604	880217	930101
FIRST PROVIDERS INC DAVID H HIGHT 2510 EAST DEMPSTER, SUITE 209 DES PLAINES IL 60016	920521	930101
FLEXICARE INC RANDY L STUART 7124 WINDSOR LAKE PARKWAY ROCKFORD IL 61111	910912	930101
FOUNDATION FOR MEDICAL CARE OF CEN ILL GREGORY M SONNENBERG 2600 FARRAGUT DRIVE / SUITE 430 SPRINGFIELD IL 62704-1486	930101	930101
FREEDOM PLAN LTD DANIEL P FRANKLIN 600 SOUTH 13TH STREET PEKIN IL 61554	911003	930101
GROUP INSURANCE ADMINISTRATION INC ROBERT H CARTER III 850 WEST JACKSON BLVD - STE 600 CHICAGO IL 60607	881004	930101
HEALTH ADMINISTRATORS INC WILLIAM LI 770 N HALSTED/STE 308 CHICAGO IL 60622	860711	930101

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ANAME	DEDAY	EFDAY
HEALTH DIRECT INC CHARLES R STARK 1011 EAST TOUHY / SUITE 500 DES PLAINES IL 60018-2808	920527	930101
HEALTH MARKETING INC BRADLEY R JOHNSON 155 HARJOR DRIVE CHICAGO IL 60601	920603	930101
HEALTH PLUS INC PHILIP C WALKER II 209 W 5TH AVE PO BOX 509 PEORIA IL 61651-0509	920818	940101
HEALTH PREFERRED OF MID AMERICA INC DAVID K WILLIAMS 244 EAST DEVON AVE / SUITE 188 DES PLAINES IL 60018	860630	930101
HEALTHCARE MANAGERS OF AMERICA INC MARTHA GABER 540 NORTH LA SALLE STREET CHICAGO IL 60610	861218	930101
HEALTHCARE PREFERRED INC LINDA SUFFICOL 317 SIXTH AVENUE SUITE 1002 DES MOINES IA 50309	910820	930101
HEALTHLINK INC TOM MERCER 788 OFFICE PARKWAY ST LOUIS MO 63141	860129	930101
HEALTHNETWORK INC GEORGE C PHILLIPS 1420 KENSINGTON RD OAK BROOK IL 60521	860124	930101.
HFN INC DAVID KOLB 1315 22ND ST / SUITE 405 OAK BROOK IL 60521	900101	930101
HUMAN RESOURCE CONSULTING GROUP /THE DR STEVEN M JULIUS 520 NORTH MICHIGAN AVE / SUITE 1212 CHICAGO IL 60611	930524	930524

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NAME	OE04Y	EF04Y
ILLINOIS PACIFIC DENTAL INC WILLIAM LI / DDS 770 NORTH HALSTED STREET #308 CHICAGO IL 60622	890101	940101
INDEPENDENT EYE CARE CENTERS INC LEONARD N SABLE 7918 LONG AVENUE MORTON GROVE IL 60053	901115	930101
INDUSTRIAL HEALTH CONSULTANTS INC NICHOLAS C CARO M.D. 2350 EAST DEVON AVENUE DES PLAINES IL 60018	881118	930101
LABORCARE INC DVE R JERZY 7366 NORTH LINCOLN AVE / SUITE 304 LINCOLNWOOD IL 60646	900301	930101
LINCOLNLAND PREFERRED PROVIDER INC JACK D DAVIS 1244 E SANGAMON AVE SPRINGFIELD IL 62703	930622	930622
LUTHERAN GENERAL HEALTH PLAN RONALD FERGUSON MD 1661 FEEHANVILLE DRIVE SUITE 200 MT PROSPECT IL 60056	880321	930101
MANAGED BEHAVIORAL CARE INC SAMMY SQUIPE 1341 RAND ROAD DES PLAINES IL 60016	920128	930101
MANAGED CARE OPTIONS INC SUSAN J DIVITA 111 LINDS DRIVE / SUITE 207 BARRINGTON IL 60010	911021	930101
MANAGED HEALTH SYSTEMS INC MARY JANE SUCH 1120 TYRELL PARK RIDGE IL 60068	920729	930101
MCC BEHAVIORAL CARE INC CHERYL ID 11075 VIKING DRIVE, SUITE 350 EVEN PRAIRIE MN 55344	920424	930101

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ANAME	DEDAY	EFOAY
MEDICINE SHOPPE INTERNET INC GARY M LEVINE 1100 N LINDBERGH BLVD ST LOUIS MO 63132	911113	930101
MIDWEST BUSINESS MEDICAL ASSOCIATION LTD JAMES M GOLDEN 5901 NORTH CICERO AVE SUITE 207 CHICAGO IL 60646	860411	930101
MUTUAL MEDICAL PLANS INC RON JONES 415 MAIN / SUITE 1025 PEORIA IL 61602	930202	930202
PDC MANAGEMENT SERVICES INC JAMES V D'ALISE DDS 340 BUTTERFIELD ROAD / SUITE 1C ELMHURST IL 60126	911219	930101
PERSONALCARE HEALTH MANAGEMENT INC ALAN L MYTTY 510 DEVONSHIRE DRIVE CHAMPAIGN IL 61820	880101	930101
PPD JOLIET CHARLES E HEDKE 2450 GLENWOOD AVE JOLIET IL 60435	860313	930101
PREFERRED CARE NETWORK INC THOMAS H STATEMAN 7257 NO LINCOLN LINCOLNWOOD IL 60646	860127	930101
PREFERRED HEALTH CHOICE INC W R VAN VLEET 304 NORTH MAIN STREET ROCKFORD IL 61008	910402	930101
PREFERRED PLAN INC ROBERT J CURRY 10600 WEST HIGGINS RD / SUITE 405 ROSEMONT IL 60018	870102	930101
PREFERRED PODIATRY GROUP INC MR SANFORD MASON 4650 FORESTVIEW DRIVE NORTHBROOK IL 60062-1010	870408	930101

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ANAME	DEDAY	EFOAY
PRESTON GROUP INC THE RANDALL E PRESTON 167 COUNTRY COMMONS ROAD CARY IL 60013	910502	930101
PRINCIPAL HEALTH CARE INC PATRICK CHARLES FRAIZER 310 S MICHIGAN AVE SUITE 1300 CHICAGO IL 60604	911209	930101
PRIVATE HEALTHCARE SYSTEMS LTD GENE P. GUSELLI 10255 W HIGGINS / SUITE 260 ROSEMONT IL 60018	901205	930101
PROAMERICA NETWORK INC DONNA HILL 714 MAIN STREET FORT WORTH TX 76031	900403	930101
PSYCHCARE CONNECTIONS INC DOLORES KAPRAL 7346 N MONTICELLO AVE SKOKIE IL 60076	920101	930101
RESOURCES PLUS NETWORK LEANDER E MIKELL ONE NORTHFIELD PLAZA / SUITE 300 NORTHFIELD IL 60093	930101	930101
SANUS PASSPORT/PREFERRED SERVICE INC KELLY RICHESON 969 EXECUTIVE PARKWAY ST LOUIS MO 63141	900403	930101
SOUTH COOK INDEPENDENT PRACTITIONERS INC MC MORROW STAN P O BOX 93 CHICAGO HEIGHTS IL 60411-3433	860827	930101
SPECIALTY CARE OF ILLINOIS CYNTHIA L TATE 205 N MICHIGAN AVENUE SUITE 3800 CHICAGO IL 60601	900123	930101
STAFFCORP INC FREDRIC KULLBERG 1313 EAST STATE STREET ROCKFORD IL 61104-2227	870112	930101

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ANAME	QEDAY	EFDAY
STRATEGIC HEALTH CARE MGMT SERVICES INC CARMEN F MONACO 2250 EAST DEVON AVE / SUITE 225 DES PLAINES IL 60018	870127	930101
SWEDISHAMERICAN HEALTH ALLIANCE CORP CHARLES S DE HAAN MD 1313 EAST STATE STREET ROCKFORD IL 61104	900726	930101
TAKECARE ADMINISTRATIVE SERVICES CORP MICHAEL S YOUNG 2300 CLAYTON ROAD CONCORD CA 94520-2100	921005	930101
U S BEHAVIORAL HEALTH EUGENE D HILL 2000 POWELL STREET / SUITE 1180 EMERYVILLE CA 94608	910705	930101
ULTIMED HEALTHCARE NETWORK INC TIMOTHY M KEARNS 501 TENTH AVENUE MOLINE IL 61265	910305	930101
USA HEALTH NETWORK ADELE FRENCH 7301 N 16TH ST / SUITE 201 PHOENIX AZ 85020	900302	930101
VISION HEALTH MANAGEMENT SYSTEMS INC ROBERT LEE JOHNSON 2828 SOUTH INDIANA AVENUE CHICAGO IL 60616	870220	930101



STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD, ILLINOIS 62767

March 25, 1994

OFFICE OF THE ASSISTANT DIRECTOR

The Honorable Cardiss Collins
Chairwoman
Subcommittee on Commerce, Consumer
Protection and Competitiveness
U. S. House of Representatives
Washington, D.C. 20515-6120

Dear Representative Collins:

We appreciate the opportunity to provide you with the additional information requested in your letter of March 10, 1994.

Question 1.a. *In your February 23, 1994 letter, you stated that, "Preferred provider networks administered by insurers are not subject to the PPA registration requirements of the Health Care Reimbursement Act." Yet, in your written testimony for the February 14th hearing, you stated that, "Licensed insurance companies can also form PPAs and, since the passage of the Health Care Reimbursement Act, the Department has approved approximately 140 separate insurance policies, containing preferred provider options, from 80 different insurers." How do you reconcile these two statements?*

Answer: The Health Care Reimbursement Act states that its requirements are not applicable to insurers unless specifically provided (215 ILCS 5/370j). The registration of insurers is therefore excluded. No insurer may issue or deliver a policy or contract of insurance in Illinois until the form and content of such document has been filed with, reviewed and approved by the Director of Insurance (215 ILCS 5/143). The Department is required to compile and maintain a listing of insurers who file policies or contracts of insurance which contain a preferred provider option (215 ILCS 5/370k). Since the passage of the Health Care Reimbursement Act, we have maintained such information.

Question 1.b. *Since your Department apparently does have some regulatory role with regard to insurance company and other PPAs, do you monitor them with regard to the degree of service they provide to various geographic, racial and ethnic communities within the Chicago metropolitan area? If you do, what are your findings, and if you do not, then who does? If no one has this responsibility currently, do you think it should be given to someone?*

Answer: The Illinois legislature has not given this Department or any other agency

the statutory authority to monitor preferred network locations provided to geographic, racial or ethnic communities. Currently, no agency has the responsibility for monitoring the amount, type, or location of care rendered through preferred provider arrangements. If the environment of American health care evolves so as to "lock" the public into managed alliances, accountable health plans or some other closed delivery system, there must exist a regulatory body which is responsible for ensuring physical accessibility of its members through the availability of health care providers.

It is important to note that in Illinois, PPA networks are not closed. The Illinois General Assembly specifically addressed this issue within their debates by stating that the passage of the Health Care Reimbursement Act was not meant to establish "Exclusive Provider Organizations." Exclusive Provider Organizations or EPOs require the member to use the services of contracted providers or be turned down for the cost of care received. Rather, what was intended with the passage of the Health Care Reimbursement Act, was the ability to provide an incentive to use the services of a preferred provider by offering greater benefits or lower out-of-pocket expenses. The members still retain the right to go to any provider of their choice. Access to care is never impaired by virtue of the existence of a preferred provider network.

Question 1.c. *In your written testimony from February 14th, you reached the conclusion that, "This would appear to point toward a comprehensive array of health care services. These services are available through the mechanism of network care, resulting in greater coverage and lower costs for the consumers of Illinois." If your role with regard to PPAs is merely to maintain information relating to their registration requirements, on what basis and with what information did you reach the above conclusion? What does your Department know about the degree to which PPAs are generally accessible and offer greater coverage at lower costs for residents of the west and south sides of Chicago?*

Answer: Testimony which addressed a "comprehensive array of health care services" referred to the fact that there exists a broad range of PPA arrangements, including major medical, hospital/surgical, vision, dental, and pharmaceutical services as evidenced by the information required to be maintained pursuant to 215 ILCS 5/370j. The statement that, "This would appear to point towards general accessibility" represents an assumption based upon the total number of insurers offering PPAs, the number of policies which have been approved containing a PPA option and the fact that the Department has not received a pattern of complaints which would indicate accessibility problems.

Question 1.d. *At the February 14th hearing, you indicated that there is no prohibition preventing PPAs from soliciting participation of particular providers "even if it is done on a picking and choosing manner that could have discriminatory implications". Do you think it is appropriate that Illinois consumers should have no statutory protection from their Insurance Department against such redlining? Do you think that your Department should exercise its general insurance regulatory authority to monitor and prevent such activities?*

Answer: The Health Care Reimbursement Act states that an insurer or administrator shall not refuse to contract with any noninstitutional provider who meets the terms and conditions established by the insurer or administrator (215 ILCS 5/370h). Once an insurer or administrator defines the terms under which they are willing to enter into a preferred provider contract, any qualified provider must be allowed the opportunity to participate. The statute does not allow arbitrary picking and choosing of providers.

Question 2. *At the February 14th hearing, I had requested information on how well PPAs serve residents of the west and south sides of Chicago. The information which accompanied your February 23d letter listed PPAs only according to their registered addresses (presumably their corporate main offices). Could you please provide the information that had been requested with respect to the locations and service areas of the providers whose services are offered through PPAs?*

Answer: Please see attached listings and provider booklets.

Question 3. *At the February 14th hearing, you stated that, "We have got statistics that show that there is a (HMO) provider location in virtually every zip code in the city of Chicago." I am pleased to know that you have detailed information about the locations of HMO-affiliated providers. Do you feel that one provider per zip code could be sufficient enough to satisfy the demand for health services throughout the Chicago area, particularly in underserved communities?*

Answer: This Department does not have the technical expertise to answer your question. The Illinois Department of Insurance has been charged with the regulatory oversight of the business of insurance. The decision as to the adequacy of providers is the statutory responsibility of the Illinois Department of Public Health. Within the HMO Act, the Director of the Illinois Department of Public Health is responsible for seeing that an HMO has demonstrated the willingness and potential ability to assure that health care services will be provided in a manner to insure both availability and accessibility of adequate personnel and facilities and in a manner enhancing availability, accessibility, and continuity of service (215 ILCS 125/2-2).

Question 4. *The Illinois Department of Public Health has stated that, while they do regulate HMOs with regard to the capacity of the HMO to serve their enrollees and the number of providers needed to do so, they do not regulate HMOs with regard to the location of those providers. In particular, they do nothing to prevent an HMO from engaging in redlining to avoid minority or low income communities. Thus, an HMO network could be designed to serve only a particular segment of the population or a certain part of the Chicago area, and the IDPH would not look into such a discriminatory practice. Meanwhile, in your February 23d letter, in the paragraph relating to your Department's authority with respect to HMOs, you wrote, "The scope of the Department's regulation is limited to activities specific to the business of insurance." Does your Department think that HMOs should be prevented from redlining? If so, in light of the traditional role of the Insurance Department in policing against redlining and the continuing*

interpretation of redlining as a matter of the "business of insurance," which governmental department should be responsible for preventing such practices?

Answer: In the context of the business of insurance, "redlining" is unfair discrimination by the insurer or HMO in the sale of the policy of insurance or the group master contract. The statutes regulating "redlining" in the property and casualty arena (215 ILCS 5/155.22) and discrimination in health insurance (215 ILCS 5/364) both refer to the issuance of policies. The Department thinks that HMOs should be prevented from unfairly discriminating when they issue group master contracts (employers not individuals are usually the customers of HMOs). The Department's role is and should continue to be the regulation of HMOs when they unfairly refuse to contract with an employer. At the present time, there are no statutory restrictions on HMOs in establishing their service areas. Once an HMO has identified its service area, it must provide care which is both adequate and accessible. Currently, the Illinois General Assembly has given the Illinois Department of Public Health the statutory mandate to ensure that adequate personnel and facilities exist to provide availability, accessibility and continuity of health care services for all members of the HMO (215 ILCS 125/2-2). The Department believes that IDPH should continue to play this role since it has the expertise to evaluate provider sufficiency.

Question 5. *In your written testimony for the February 14th hearing, you stated that, "Every . . . provider network should be licensed," and that there should be, ". . . various prerequisites for licensure." Does your Department believe that the prerequisites for a license should include participation of providers in equal proportion in communities of all types, as characterized by the residents' race, ethnicity, income level, and percentage of government aid recipients?*

Answer: Within the Department's written testimony, we stated that any licensing activity must be based upon the qualification, competency, and financial ability of a provider network or health care alliance to perform. This should be the first concern of ensuring adequate and accessible care. As networks mature within a given location, such networks tend to mirror the characteristics of the community they serve. I do not know of any health care initiative which would require provider representation concomitant with the ethnic, racial, or income level of the people they treat.

Question 6. *In your February 14th testimony, you mentioned, in the context of unfair trade practices, that such prohibitions could be tailored to address provider networks. Could you please elaborate on how this would be applied and roughly what resources would it take to do the job effectively?*

Answer: As we have stated, in a health care reform system involving universal coverage, we believe, "Every . . . provider network should be licensed," and that there should be, ". . . various prerequisites for licensure." One of the prerequisites could be the applicability of the unfair trade practices statutes and/or regulations. While some regulatory tailoring would be necessary to put unfair trade practices into the networking context, it is something that

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can be accomplished. For example, an unfair trade practice that prohibits any unfair discrimination between individuals . . . because of race, national origin, etc. could be made to apply to networks so that any unfair exclusionary practices would be prohibited.

The resource requirements should not be excessive if there are appropriate reporting requirements. Through licensure we could track the networks and the location of their providers. This could be expanded to type of provider to verify accessibility to various services.

Very truly yours,

Madelynn L. Brown ⁴⁵

Madelynn L. Brown
Assistant Director of Insurance

MLB:dj

cc: James Schacht
Mark Peterson

Mrs. COLLINS. Well, I hope you have. Otherwise, I am wondering why your department is in existence. You don't seem to have any of the information we want.

Mr. McNary, what is your assessment of the situation as to HMO's and PPA's serving the west side and the south side of Chicago and other communities in Chicago?

Mr. McNARY. I think that to underscore—first of all, I want to appreciate Ms. Brown for her honesty with the Department of Insurance not having that data and information. And if I could take your question to another point, I—

Mrs. COLLINS. I want you to answer my question first and then take it to another point.

Mr. McNARY. OK. I will let—John Cameron is looking over some information about the provider networks and how they are located by the zip code that you had.

Why don't you answer that? I will defer to John Cameron on that.

Mrs. COLLINS. Well, he has to identify himself for the record. Have you already done that?

Mr. McNARY. He has already done it for this gentleman.

STATEMENT OF JOHN D. CAMERON

Mr. CAMERON. I am John Cameron, associate director of Illinois Public Action.

The question, I think it is the point of adequacy of access to care and I think Dr. Greenspan, you know, pointed out earlier that this is not just a question of having universal coverage, but having both access to the care that people need as well as having the appropriate kind of care that is necessary in those communities.

And so the mere location of how many institutions are located in a zip code does not speak to really this issue. And I think that is—you know, the thrust of our testimony is that the rapid expansion of provider networks and managed care operations has not in any way provided the level of care needed in the west side as well as in the south side communities.

And consequently, any policy that is based on expanding that dramatically in the future will not address those, as I think we have heard this morning both from Mount Sinai Hospital and also the representative from Cook County Hospital.

I really think the department merely maintains a list of addresses essentially. It does not—as Ms. Brown has said, it does not in any way authorize nor intends to go out and find: Are they providing care in those areas? What kind of care is provided? Is it appropriate care? The different kinds of care that are being provided.

So, you know, I think Mr. McNary wanted to make a point on that aspect of the issue as well.

Mrs. COLLINS. Mr. McNary.

Mr. McNARY. And that is the point I wanted to make is that a lot of—both the proposals that we are looking at, the Clinton proposal and the Cooper proposal, demand too much regulation be left in the hands of the Department of Insurance.

In our experience, and you can see by the experience today, that would be a disaster for consumers because the Illinois Public Department of Insurance in the past views this function on very nar-

row terms, primarily just policing whether the plans are solvent or not.

Mandating that the department play a broader role in assuring consumer satisfaction, restricting discriminatory behavior and assuring compliance with Federal mandates is well beyond the scope of this department and clearly beyond its political will.

In fact, the Department of Insurance in Illinois has a long record of serving as a captive agency of the industry that it is supposed to oversee. Its policies are formulated at the bequest of the industry. Its positions over and over again on consumer issues mimic those of industry. And its top policy personnel regularly move through the revolving door, taking positions with the industry after serving as its regulators.

It has never demonstrated any independent initiative in battling for consumers against the industry. Its compliance with consumer protection requirements within the State law is minimal and thus the prospect of significant new responsibilities with the Illinois Department of Insurance talking about quality and access to care will be a consumer nightmare.

Mrs. COLLINS. Ms. Brown, you may or may not be aware that I have been actively trying to work toward the elimination of redlining practices by property and casualty insurance companies. Recently consumer advocates have expressed concern that your Department watered-down an NAIC proposal to studying redlining in Chicago and other areas, which is what reference has been made to.

Your department responded, while it would be happy to investigate specific complaints, it would prefer to get new companies into the market rather than to do any targeted redlining exams. That is like saying that a restaurant can exclude African-Americans as long as there are other restaurants they can choose from.

That attitude is unacceptable and not to be tolerated no matter how many companies are in the market. In light of your department's views, my question is: How do you believe that Chicago area consumers can be assured that a reformed health care plan will effectively prevent discrimination or redlining in the health care area?

Ms. BROWN. Madam Chairwoman, our department is not and never has had the viewpoint that redlining is acceptable. I would like to state that to start with.

I think the issue in the property and casualty arena is one of approach, not one of saying that the problem is not something that needs to be dealt with.

In terms of the decision to encourage additional companies to write, that was based on the fact that the significant—the companies that do write do a significant portion of the business. So they are already writing a variety of areas.

We determined that it made sense to get more and more companies in there doing the—to also write. Those are the people, the people who are actually not doing anything at all in the city. We need it to get them in cities and working and doing business.

Mrs. COLLINS. I use that as an example of the kind of attitude or the kind of—I don't want to go so far as policy, but the kind of result that has resulted in—the action or inactivity that has re-

sulted with some of the things that has happened in your department regarding casualty and property redlining.

Medical redlining is going to be a much larger problem affecting every individual in the State of Illinois. Under both the Clinton and other proposals—there are a myriad of proposals floating around Congress—how is the State of Illinois Department of Insurance going to look, and what kind of plans are you going to put in to prevent medical redlining, which is much more serious when you start thinking about medical care for the people who live here, since every individual who is born on the earth is going to have a medical problem, if no more than just getting born, that requires a medical activity of some sort.

I am wondering what thought has been given to prevent this kind of discrimination: medical discrimination.

Ms. BROWN. Medical discrimination in terms of from the Department of Insurance perspective would be just as heinous as property and casualty discrimination. We—if given the responsibility for regulating that, we will do whatever we could in terms of implementing standards that were imposed and enforce these regulations.

At this point in time, I just—we don't know the exact form of an ultimate health care reform bill or the exact responsibilities our department would have in that arena.

Mrs. COLLINS. Let me ask you this: Has the State of Illinois been paying any attention at all to the debate that has been going on in this entire country about health care and universal health care?

The President and Mrs. Clinton and Mr. Magaziner and everybody, every time I turn on the television, they are talking about this health care bill. This has been going on for well over a year.

Are you telling me that my State hasn't given any consideration at all to how it is going to act?

Ms. BROWN. No, ma'am. What I am saying is that the Department of Insurance—the Illinois Health Care Reform Task Force was the focal point in the State of Illinois for this issue. It is not the Department of Insurance, and I am not in a position to speak for the entire State for this issue.

Mrs. COLLINS. You are the assistant director of insurance for the Illinois Department of Insurance?

Ms. BROWN. Yes, ma'am.

Mrs. COLLINS. What is your responsibility?

Ms. BROWN. My responsibilities are to support the director of insurance and to follow any instructions that the director gives me. I am involved in trying to eliminate property and casualty redlining where it might exist.

I provide some staff support to the Illinois Health Care Reform Task Force.

Mrs. COLLINS. Mr. Greenspan, the President's proposal, health care proposal includes use of a risk adjustment mechanism to adjust payments to health plans to reflect the level of risk and costs associated with their patient base, and as long as that is in place, what reasons, if any, would there be for a health plan or provider network to not want to contract with a hospital such as yours?

Mr. GREENSPAN. Madam Chairwoman, recently at a meeting, a noted economist spoke up about the President's plan and noted the importance of establishing universal access. He then went on to

discuss the imprecision of risk adjustment and the difficulty in accommodating those risks that are tending to social and environmental aspects that cost additional resources in health care.

It is very unlikely in our opinion that those barriers will be overcome readily. There are problems not only of those individuals who will continue to remain uncovered because they haven't been properly documented and living in large numbers in our communities—we estimate that 4 percent of the patients admitted to our hospital are undocumented—but also they won't accommodate any, in risk adjustment, of the factors that never enter into a DRG-like assessment of health care.

I want to give you one small example, if I may. Recently we had the honor of providing care for three individuals who were shot while driving their car through our neighborhood. It turned out that those three individuals were executives of an organization in our community that provides illegal substances throughout the west side of Chicago. They drove themselves to our facility for care, received care, and in the process of taking care of them, we had to provide round-the-clock security. We had to secure perimeters around our institution, not only to safeguard the three individuals, but every other patient who came and went from our facility.

And we had to continue that level of alertness to comfort the providers who work in the institution who need to be able to be comfortable coming in the middle of the night. These kinds of adjustments are never going to enter into a DRG-like risk adjustment.

One more small example, if I may beg your indulgence. We provide millions of dollars in community health services, some of which we fund ourselves. We do this because they work. One small program is called the Problem Pregnancy Program. It is provided with State assistance, public health department assistance. The Problem Pregnancy Program costs \$30,000 per year to monitor. Last year 150 women who were pregnant and at high risk, at least 20 percent of whom should have delivered high risk, low weight; not a single one was delivered.

Where is the \$30,000 going to come to from unless somebody is attending to specific historic environmental and social factors that need to be overcome? If we want to accommodate an outcome that says all Americans will have optimal health, then we need to get beyond the measurement in an actuarial sense of how many dollars into this category and how many dollars in that category and deal with the problems of health.

Mrs. COLLINS. For a hospital such as yours participating in this plan as detailed in the President's proposal, would you have any preference between participating in an HMO or some other type of arrangement, Mr. Greenspan?

Mr. GREENSPAN. We believe that in the long run capitation is the best methodology. Frankly, most of us are supporters of the single-payer system. We have seen the effects of differentiating resources and spreading them unequally throughout the community.

You have made my Valentine's Day, Madam Chairwoman. You raised the issue of redlining, something we have struggled with for 2 decades. We believe that medical redlining is looming as a disaster as long as competitive management is injected into the system.

We believe that it has already been in the system in an adverse way and that if one explores in detail the movement of insured patients from inner city hospitals to mainstream hospitals, one will see that the expansion of HMO's and PPO's has in fact accelerated in differentiation of commercially insured dollars going to inner cities.

Mrs. COLLINS. A couple more here and then I think I will be through here.

Ms. Brown, you mentioned in the context of unfair trade practices that such prohibitions could be tailored to address provider networks. Would you elaborate on how that might—how we could apply this and roughly what resources it would take to do this job effectively?

Ms. BROWN. The—there is an existing Unfair Trade Practices Model Act and the act goes into great detail—goes into detail as to exactly what sort of things are unacceptable behavior.

It would be necessary to rewrite that act in order to spell out exactly what was acceptable or unacceptable in terms of location of provider network operation and then it would be necessary for whatever the oversight agency is to be able to examine and audit networks to make certain they were following the requirements of such an act.

Mrs. COLLINS. Mr. McNary, what do you think of the Uniform Trade Practices Act? Do you think it provides sufficient statutory framework from which to operate, and do you also think that the Department of Insurance is properly equipped to properly enforce it? Either one of you two.

Mr. McNARY. Why don't you take it?

Mr. CAMERON. I won't comment on the Trade Practices Act, but I do think in general our experience with the Department of Insurance is that they take the most minimalist approach to enforcing any of the laws that they are statutorily obligated to enforce as it comes to consumer protections and assurances that we get equal access to care.

The lengthy series of interactions that this subcommittee has had with the department over the question of insurance redlining in the auto and homeowners area I think really underscores that.

Their consistent fronting for the industry by refusing to stand up for the consumer, to demand information about how service—coverage is being provided, if it is being provided fairly and adequately, and if there is—and their lack of fulfillment of the statutory mandates they have under existing Illinois law to do that really underscores what we feel will be a looming nightmare.

And when Dr. Greenspan talks about the advent of medical redlining becoming much worse under reform, we will have nothing but this department under the current law as it is proposed in the Clinton bill to protect us from that, and to us that is a disaster.

I think that is—that is guaranteeing that there will be no protections for consumers in that area, and I know that your district as well as the other urban communities in Chicago are going to be the hardest hit by that, as in many other urban areas across the country.

So, you know, I think we can't underscore too strongly the grave concerns we have with leaving this with a department of insurance, especially this Department of Insurance.

Now, other States have more aggressive directors, they have more aggressive departments. Some States, like California, have an elected commissioner who is very aggressive on behalf of consumers, so this is not uniformly true across the country, but clearly here in Illinois, our Department of Insurance services is little more than an appendage of the insurance industry, and we think that would be a disaster for us under the health care reform that has been proposed.

Mrs. COLLINS. As in the last panel, in the event there is something that you haven't said, I would like to ask you, Mr. Greenspan, are there any closing remarks you would have to add or anything further that you wanted to say and didn't get a chance to say at this time?

Mr. GREENSPAN. Thank you. I would like to simply say one thing for the committee members and that is it is imperative that we remember that while universal coverage is a laudable goal, first, it must be truly universal and, second, universal coverage is not the same as universal access.

There are many ways in which a system aimed at a process of taking profits out of the process of care can maximize their profit potential and all of those ways come down to excluding those individuals who represent the greatest cost and the greatest risk.

If our goal in national health reform is to improve the health of all Americans, to optimize the health, give all Americans the best chance at being productive, then we cannot rely on a system aimed at profiting from that process.

Thank you, Madam Chairwoman.

Mrs. COLLINS. Thank you.

Ms. Brown.

Ms. BROWN. Yes, Madam Chairwoman.

I wanted to add that the Department of Insurance is totally concerned with protecting the consumers. That is $\frac{1}{2}$ of our mandate. We do that both in terms of examining the market conduct of insurance companies and also the major thing is that they are solvent, that they can pay their bills.

If they can't pay the claims and keep the promises they have made, then they can't provide any services to any consumer. That is one of our primary objectives.

To go back to the property and casualty redlining issue, we have been obtaining data regarding homeowners insurance in the State for well over 10 years now. Our data shows that in areas of—in urban areas in the city of Chicago that well over 90 percent of homeowners have insurance. We think that—we are collecting the kinds of data that I believe your committee has been looking at.

We believe that if our agency is given the opportunity to implement whatever scheme is developed in legislation that has yet to be finalized, that we can handle that also. But I do want to state that there hasn't been—our agency is only one of the agencies in the State that regulates health care at this point in time.

There has not been a determination that the Department of Insurance would be the regulatory agency or the oversight agency in a new system.

Thank you.

Mrs. COLLINS. Mr. McNary.

Mr. McNARY. It was said earlier that under the Clinton proposal there will be 70 new State bureaucracies or government bureaucracies created in order to enforce it. What we don't need in any health care plan is any new barriers to care. That is for sure.

But I would rather take my chance with 70 new bureaucracies created to ensure fairness as opposed to the current 1,500 different health insurance bureaucracies who now take 37 cents for every dollar that they deliver for administration. I would much rather take my chances with a bureaucracy that supposedly, if we are going to call it a bureaucracy, is someone who stands to make sure that high quality, affordable health care is available to all Americans.

The fact of the matter is this: Very simple, redlining exists in property and casualty insurance. We cannot afford to assume that just because we pass a bill that says that discrimination will not exist, we should not assume that we must not be vigilant in order to make sure that it does not.

We want to thank Chairwoman Collins for consistently looking out for those who are least able to look for themselves. They will be the ones that need the most protection under any health care reform plan and we thank you for your strong support of health care reform in Illinois.

Mrs. COLLINS. Mr. Cameron.

Mr. CAMERON. I just also wanted to underscore that from the discussion in the earlier panel, I mean, I think there are some very disturbing trends being laid out there that merit continued investigation by this committee.

When the two gentlemen from the major health networks here earlier talked about cutting back 27,000 hospital beds in the city of Chicago by the end of the century, what they are talking about is not uniformly reducing, they are closing a wing at their hospital and one at Rush and one at Northwest.

They are talking about shutdown of specific institutions. Those institutions we have already seen that happen are like Saint Anne's in your district. We are talking about that happening again.

We pointed out in our testimony we are concerned about the future of Bethany. There are many other hospitals. Dr. Greenspan talked about Mount Sinai itself being in jeopardy.

What we are talking about and the image that is being laid out there is a competitive marketplace where the major hospitals are fighting not over who provides the best care or the care where it is most needed or, rather, who has what share of the market and who has the best coverage for the insurer, I think, underscores a very disturbing picture of where health care should not be going, health reform should not be going and where it is already committed to going that way.

Fortunately, I think in the Clinton plan there are some safeguards there to prevent that, safeguards that we have to under-

score, but they are certainly not there in the Cooper proposal and some of the other proposals that are up on Capitol Hill.

We trust that you know both the consumer protections as well as this broader question of public policy has to get much more fully aired in the coming months before we sign off on any long term health care proposal in Congress.

Thank you again.

Mrs. COLLINS. Thank you very much. I thank all the witnesses for appearing today and let me say that all of your testimonies have been especially helpful to us. There may be some questions we have for you.

If you receive a letter from us within the next few days, please respond within the next 5 working days—you already know about that, right—so that we can close our record on this.

Thank you very much, and this hearing is adjourned.

[Whereupon, at 12:23 p.m., the hearing was adjourned.]



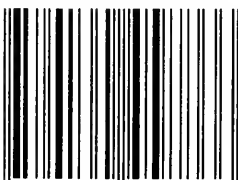
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